Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death To1son Month Physician/ Harry James 2012 5:40 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 78 Shore Road Edgemere Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Davs Hours Min. (Month, Day, Year) 214-34-6378 Director 1 🕅 M 2 🗆 F Aug. 24,1938 DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Edgemere 102 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 78 Shore Road 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 0. þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington Suburban permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Draftsman Sanitary Commission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph A. Tolson Dorothy A. Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol C. Ginsberg (Sister) 78 Shore Road Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State any injury or Hilltop Service Corp: 1/26/2012 4 Donation 5 Other (Specify) Towson, Maryland Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Mas 7922 Wise Dundalk, Maryland Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ thetec disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed 1 ☐ Yes 2 ☐ No _ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ည Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Certificate: Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Self 5 Pending injury 1 Natural 23 2012 740PM to hea Accident Investigation woun after death by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 785hove Road onever MDZIZIG determined 24 hours after Funeral Dire letely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one 29d. Date signed (Month, Day, Year) title of certific 29b. Signator 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24, 2012 Physician/ 12:24 P M Anh Thai January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 586-28-7608 1 □ M 2 🛛 F 92 Director July 4, 1919 China Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10a. State 10c, City, Town or Location Director 1 Yes 2 X No Germantown Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be i Funeral United States 20876 20385 Mill Pond Terrace death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No þ 1 ☐ Yes 2 X No Specify. Specify: Asian 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 6 Be Department of Health and Mental He.

Department of Health and Mental He.

Important: If item 27 is mediany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ೭ unknown To Hien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20385 Mill Pond Terrace, Germantown, Maryland 20876 Patrick H. Tran / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of February 2, 1 X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place Parklawn Memorial Park Rockville, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions Examine if any leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit executed Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 147 potension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 XNo 1 Tes Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred 27 Manner of Death Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The centrying rinjordant. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) DHILLES WD Janyar

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02105

Registrar

Doctors

acimantenn wb 50817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.52P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ JANUARY MARGARET VASOLD 22 2012 11:10PM Μ. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ROSEDALE FRANKLIN WOODS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Hours Min 90 _{Yrs} 215-18-5224 **Director** 1 M 2 X 5-13-1921 MARYLAND Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director ROSEDALE BALTIMORE MD 1 🗆 Yes 2 🗶 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö iral", or items 23a o Examiner must be Funeral U.S.A. 21237 7911 34th STREET filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE If Yes, Give Specify: ¾ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PRODUCTION ESSKAY MEATS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 **ANDREWS GETZ** CATHERINE FRANCIS other traumatic Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21237 DONALD VASOLD/GRANDSON 1416 A SPRING AVE ROSEDALE, MD t of Health altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If i any injury or c cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 1-27-2012 BALTIMORE, MD nature of uneral Sprine Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 CHESACO AVE ROSEDALE, 1211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 415 ACCACOLA Proveinian disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a conseque Exami burial-trar and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Dav Pregnant at time of death ed by the a g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎾 Jnknown Records, peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has autopsy funeral director, page 2 performed2 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? injury 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director, /
completely filled in by the Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

Name and address

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MP

82. Registrar's Signature

Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 22 Physician/ VALENTINE ROSETTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MILLERSVILLE KNOLLWOOD NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs, last birthday) Social Security Number **Funeral** 1<u>924</u> Hours Month, Day, NOV 14 1 □ M 2X Months WASHINGTON, DC Director 87 579-20-9202 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number iral", or items 23a Examiner must be Funeral **IISA** 20715 4018 CHELMONT LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes Give "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N GOVERNMENT SECRETARY Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ **JEFFERSON** LOUISE RUSSELL BROCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4018 CHELMONT LANE BOWIE, MARYLAND 20715 DARLENE MAJORS/DGT 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place MD VETERANS CEMETERY 2/2/1012 CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee Kelas 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest flure. Enter the diseasor beart failure Interval Between Onset and Death shock. Immediate Cause (Final Physician. nknown disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 Physician/Medical P.O. Box 68760 phy as IF FEMALE nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) atter for u in the past 12 months?

1 Yes 2 No Pregnant at time of death the a Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No pate has l 1 Yes 2 No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific **Division of Vital** 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at work? 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

(Check

only one)

29b. Signature and title of certifie

30. Name and address of person who completed

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death January Physician/ 13, 2012 11:15 a^M Thomas A. Van Vliet Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Damascus 25101 Oak Dr. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 140-12-6139 Days Hours (Month, Day, Year) 84 **Director** 1 X M 2 D F Jan. 5, 1928 NJor 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director MD Montgomery Damascus 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe r items 23a or ner must be n 25101 Oak Dr. Funeral USA 20872 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Inmortant: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner: once. Black White etc 1 Never Married 2XXMarried 1 K Yes 2 1946-52 If Yes, Give 1946-52 ρ Specify: White Maryland 21215-0036 1 Yes 2XXNo Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications Financial Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name *(First, Middle, Last)* William Van Vliet Olive Lockwood Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25101 Oak Dr., Damascus, MD 20872 Betty Van Vliet, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Uniformed Svcs. Univ. 1/17/2012 Bethesda, MD 4XXDonation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service License 933 Gist Ave. Silver Spring, MD 20910 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ UNG 1 YEAR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed ng physician and as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 Pregnant Pregnant at time of death Yes 2 No 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a, Was an Hospital or Attending Physician: The law 1 24 hours after death.
 Funeral Director: After this certificate has b prior to completion of cause of death? cate has I performe 1 Yes 2 No 2 3 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [To the I within 2 To the I only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

1611

DHMH 17 Rev 06-2011

owend

Howard T. Jacobs M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

028792

1838 Green Tree Rd. #350, Pikesville, MD

21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Harwood Mandrin Inpatient Care Center 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours 142-14-2020 91 Director 1**X** M 2 □ F Jan 21, 1921 New Jersey Usual Residence of Deceden 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. Count Director 1 X Yes 2 ☐ No Anne Arundel Annapolis MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a ner must be 720 A Rosedale Street USA Funeral 21401 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White "natural", 3 Nidowed 4 Divorced Completed Year or Dates. 1940-46 Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be of Health and Mental Hygiene.
Them 27 is marked other than "n" and cevent, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Electronics 12 Sales Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ernestine Eysoldt John Charles Wolke, Sr. 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 Baldridge Rd. Annapolis, MD 21401 Margaret German/daughter Important: If item 27 any injury or other tra 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Final Journey Crematory 01/27/12 Department of 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A Clarksville MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each | .e. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and that initiated events burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Records, cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation completely filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL LAPENTA 4 SDEEENSEHIGHW; ANNAPOLI

State Registrar

egistrar's Signatur

APENTA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Physician/ Month 9:00 AM Januar Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 4b. City J trinos 8. Date of Birth Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex Age (In yrs. last birthday, **Funeral** mare Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 □ No ma. 10e. Street and Number 9 10g. Citizen of What Country? items 23a US 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2. No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 Blace 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than "r College (1-4 or 5+) Elementary/Seconday (0-12) WORKEN onstruction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ည Williams JOVICE a other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -aun7 Windsormile, MD. 21244 item 27 Joan way Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it 1 Burial 2 Permation 3 Removal from State any injury or 1-31-2012 woodbine Journey 4 Denation 5 Other (Specify) ure of Funeral Service Licensee 3405 W. Fran wallace F.S. Balto, md. 21229 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest it failure. List only one cause on each line. Interval Between Immediate Ca (Final disease or condition resulting in death) Onset and Death Physician/ End Disease Stage Medical Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying as a consequence of the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician 68760 as IF FEMALE Jse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy performe To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 准 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 046071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDMONDSON UNIVERSITY CARE EDMONDSON BALTIMORE 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Month 1208P M Physician/ Wagner man lanuary d Medical City, Town, or Location of Death Facility Name (if not institution, give street and **Examiner** Balt no re Johns Hop Kin Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In vrs. last birthday) **Funeral** Days Hours 219 08 3592 26 Director 1 □ M 2 🕱 F Sept.27,1985 Maryland show 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director Baltimore Middle River 1 ☐ Yes 2 🎇 No Maryland 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Funeral 3932 New Section Rd. 21220 USA death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12 Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. 1 X Never Married 2 Married Yes 2 XNo permit. Page 1 and 2 should be filed within 72 hours after Completed by Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Life Guard 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Brian Francis Driscoll Deborah Jean Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3932 New Section Rd. Baltimore, Maryland 21220 Deborah Jean Wagner (Mother) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Himportant: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 1/31/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a con lequence of) Examiner Sequentially list conditions, Examiner Due to las a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Other (specify) Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 \square 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) iniury 5 Pending 24 hours after death. Funeral Director: A Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the F

complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KES-000 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar REN

31. Date filed (Month, Day, Year)

HUGHES

600

NORTH WOLFE ST. BATTIMORE MARYLAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 7913 AM Physician/ Watt Johnson Tinua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NI 4 HOSPITA ITIMOC 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 217.20.045 1 M 2 XF MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral LISA 330D Alto Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Back Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Social Security noliance Specialist 0 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည scar Johnson Maude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road Baltimore, MD 21215 Egerton tuthonu Wattu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Baltimore, MD Avaitus Memorial 30/2012 01 4 ☐ Donation 5 ☐ Other (Specify) Vaughin C. Greene Funeral Service 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Van Liberty Road Randal Istown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Electrical Activity Physiciany ulseless disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BRADY LAND, A un hnown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Other (specify) 9 Unknown P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 🔀 Onknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ᅙ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA this Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 2 🗌 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 25, 750293 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY (AND) BACTIMONE. H-contel 31. Date filed (Month, Day, Year) 2.Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marian Grace Ward 24,2012 5:50 A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Forest Hill Health & Rehab Harford Forest Hill If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign Social Security Number 8. Date of Birth Age (In yrs. last birthday) **Funeral** (Month, Day, Year) May 30,1923 Country) Maryland Hours 215-16-2367 1 □ M 2 🛣 F **Director** 88 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location Perry Hall 1 Yes 2 No Balto. Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21128 9829 Sadler Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: 3 ★ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore County School Teacher 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Margaret G. Anders James O. Mullineaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9829 Sadler Lane Perry Hall, Md. 21128 Dennis Ward Baltimore, 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1-27-2012 Balto. Md. 4 Donation 5 Other (Specify) Baltimore Cemetery 22. Name and Address of Facility Schimunek FuneralHome Inc. June of Funeral Service License 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COPI disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached fo 1 Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director, After this certificate has Is autopsy performed? No No 1 🗌 Yes 1 Yes 2 completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 🗆 Yes 2 🔊 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 12355222 5 200 S JANUARy 24,2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair mo CITW, MACPHAIL 5 Donn 32. Registrate Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WHITE YVONNE 1:15 PM RECIOUS 2012 JAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland (Month, Day Year) ug. 25,1975 Months Days Hours 1 M 2 TYF 36 Director 220-86-1715 Aug. Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director 1 X Yes 2 No N/ABaltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 21225 United States 1009 Slater Road death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. 1x Never Married 2 ☐ Married ŏ Yes 2 X No δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Catering Business Food Service 10 Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dianeia Coretha Glenn Bruce Wardsworth White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianeia Coretha Glenn/Mother 513 Arsan Ave., Apt. 2, Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/26/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor Signature of Funeral Service Licensee Alvson K 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ - ULMINENT HEPATIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 15 days EPATIC Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Exam Cause (Disease or iinjury that initiated events resulting in death) Last OAGULOPATHY burial-trans Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? र्ठ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t 2 🔀 No 25. Was case referred to medical or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director, After injury 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

3

DHMH 17 Rev 7/2009

Pilelyhouri warse

JAN 2 7 2012

31. Date filed (Month, Day, Year)

LAKSHMI N POTAKAMURI.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

70674

SOUTH HANGUER STREET,

2012

BALTIMORE, MD-2/225

HOSPITALIST | M.D

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 24 Physician/ 2012 9:25 Ам Glendora Saxe Wheeler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Masonic Home Cockeysville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours JMIV 1 1928 83 155-20-4105 New York Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Cockeysville 1 Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 United States 300 International Circle, #431 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ဥ Mildred McConnell Ralph Godfrey Saxe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 Belview Ave., Hagerstown, Maryland 21742 Patricia Wheeler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

20c. Location - City or Town, State

01/25/2012

Baltimore, Maryland 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final AThrosclectic Vos aler Physician/ yeers. disease or condition Medical resulting in death Due to (or as a consequence of) Examiner Sequentially list conditions if my leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consuluence of Exami death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Sout House to Me. Nisidn of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{Y} \) No Month 5 Other (specify) Pregnant at time of death ☐ Yes ☐ ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hio CVH, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No this certificate Sun 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 🗹 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ne Hospital or Attending Pl n 24 hours after death. Ie Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔟 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifig 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bank St 3508 MO

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oar Physician/ 13 SYLVIA Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 6. Sex Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 215-40-1706 1 🗆 M 2 🗓 F 96 06/20/1915 MD Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4001 OLD COURT ROAD, #513 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 X Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) traumatic event, the SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည HYMAN AMERNICK MINNIE KOLODNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 1 OAK HOLLOW COURT, BALTIMORE, MD 21208 JAY FEINGLASS/SON item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Important: If it any injury or o ŏ 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH 01/26/2012 BALTIMORE, MD Signal up of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MG 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complied ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter Undarlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Pregnant at time of death the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 Residence pletely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural (Month, Day, Year) 5 Pending injury 2 Accident 3 Suicide 4 Homicide 1 Yes 2 🗌 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State)

Division of Vital To the Hospital or Attending within 24 hours after death To the Funeral Director:

Box 68760

P.O.

Registrar DHMH 17 Rev 06-2011

Medical

29a. Certifie (Check

only one)

29b. Signature and title of certifier

and address of person who completed cause of

death (Item 23a) (Type,

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: Jette best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Physician/ 2:059M MELINEE YERRELL 30K Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner ST. ELIZABETH NURSING CENTER N/A BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Days 1 □ M 2XX Months Hours Min VIRGINIA Director 97 231-12-4648 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 X Yes 2 ☐ No BALTIMORE OWINGS MILLS MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3414 ASSOCIATED WAY APT 308 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian. Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha RETAIL -12--0-SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES EDWARD PINKY ELLEN HARROD Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is EVELYN C. CEPHAS (GODDAUGHTER) 8621 WILLOW RUN RD. WINDSOR MILL, MARYLAND 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Cremation 3 ☐ Removal from State 1 🗆 Burial 💋 METRO CREMATORY 1-20-2012 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) Signature of Fineral Service Licensed ONATHAN D. HIBNER22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part II Enter the disease, or complications that caused should or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Between Onset and Death r respiratory arrest. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine If any, leading to himsedate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of for use as the bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 20 No Month Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 20 9 ☐ Unknown 9 Unknown P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Physician: The law requires No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes a No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t To the Hospital or Attending Natural 5 Pending work?
1 Yes 2 No death. Accident Suicide Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 L 3 L Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated.

BU

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certific

WEI den

completed cause of death (Item 23a) (Type, Print)

29c. License number

JENNIFER ELGINE ANDERSON JANUARY 21,2012 1245

		1	For State Registrar	State of Ma	aryland		irtment of F tificate of D		a Mental Hy	gierie Reg. No. 2	012	02015
	Physicia		1. Decedent's Name (First, Middle, L	.ast)					2. Date of De _ Month	Day	2012	3. Time of Death
and the same	Medic	al .	Jennifer Elain			-	# 01 T	ttion of D	Januar			12:45 PM
	Examin	er	4a. Facility Name (if not institution, g				4b. City, Town, or Rockvi		eatn		inty of Death ntgome	
April of the second	Funeral		Shady Grove Ho 5. Social Security Number unk 6		(In yrs, last	birthday)	If Under 1 Year	If Under 24 I		th	9. Birth	place (State or Foreign
	Director		3	1 □ M 2 🗓 F	60	Yrs.	Months Days	Hours M	Nin. (Month, Da		Cou	ntry)
	, wc		Usual Residence of Decedent 10a State 10b County		40- 01 3	P 1			Aug 24	1951		Virginia 10d. Inside City Limits
	ryland -f sh	cto	, out office			Fown or Loc						1 Yes 2 X No
	r 28a notif		MD Mont	gomery	Ge	altner	sburg			10a. Citizen	of What Cou	intry?
	with th	Funeral Director	19808 Wheel Wi	right Drive			20878			USA		,
	er mu	ı,	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of Hi	spanic Origin?	(Specify Yes or No-		Race - Amer	
9	fter d	by	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 1	No		Yes, specify Cubar		Jerto Nicari, etc.)		Black, White, c <i>ify:</i> Wh	ite
8	ours a tural' al Ex	ted	3 ☒ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates.								
21215-0036	72 ho n "na Aedio	Completed	(Specify only highest	grade completed)		(Give k	ent's Usual Occupa ind of work done d ONOT use retired)	uring most of	working	16b. Kind (of Business/l	ngustry
212	within giene. er tha the I		Elementary/Secondary (0-12) 12	College (1-4 or 5- 2	+)	1eg	al secre	tary		Lo	ckheed	
pu	al Hyg		17. Father's Name (First, Middle, Las						Name (First, Middle,			
yla	lid be Ment narke natic e	욘	David Tyler Fra						ie Elaine			
Mar	shouth and 7 is not traum	Ì	19a. Informant's Name/Relationship									Code) 2601 S.
e,	and the Healt tem 2		David Ralph Fra	zier - brot	_		sition (Name of	iter br	#1241; I		ion - City or	
nor	age 1 ent of nt: If ii y or o		1 Burial 2 Cremation 3	☐ Removal from State		netery, cren	natory or other plac	e)				
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ense / ////	ctor	22			State Ana	-		
ш	20 E # 0		ZIVVY	swell					re St; Ba		e, MD	
			23a. Part 1. Enter the disease, or co shock, or beart failure. List onl	y one cause on each line					diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
al-	Medical		Immediate Cause (Final disease or condition resulting in death)	_a fatal			arrhy th	mior			-	
_	Examiner	Ш	Tooding in doding	Due to (or as a	consequer	nce of):						
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequer	nce of):						
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
_	icate be executed physician and is the burial-transit	al E	resulting in death) Last	Due to (or as a	consequer	nce of):						
760	cate to physics the	ledical		d								
89	ath certifica attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnanc	2		230	, Date of del	ivery
Box 68	death le atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 😿 No	4 ☐ Pregnant at			Other (specify)	·y			Month	Day Year
P.O.	requires that the des been signed by the s should be detached	Phy	9 Unknown Part II. Other significant condition		ut not result	ting in the u	nderlying cause alv	en in Part I	23e Did	tobacco use	contribute to	the cause of death?
٠ <u>.</u>	es tha signec	ğ	Fart II. Other significant condition	s contributing to death be	ut not resur	ang in the a	nachying dadac gri	or mr arr				robably 4 Unknown
sp.	requir	etec							24a. Was			opsy findings available
eco	has has b	Completed							— auto	opsy ormed?	prior to death?	completion of cause of
Ĕ	n: The ificate or, pa		25. Was case referred to medical	1			26 PI	ace of Death (1 \(\sum \) Yes Check only one)	2 No	1 L Yes	2 No
/ita	/sicia s cert	To Be	examiner? 1 ✓ Yes 2 No	Hospital:	ent 2 KF	R/Outpatier	at 3 DOA Othe	ar:	ng Home 5 Res	idence 6 \Box	Other (Speci	ifv)
of	g Phy er thi		27. Manner of Death	28a. Date of injur (Month, Day	y 2	8b. Time of injury	28c. Injury	y at	28d. Describe			
on	endin eath. or: Afi the fu	fica	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion	,	,,	M 1 🗆	Yes 2 No				
Division of Vital Records,	To the Hospital or Attending Physician: The law *equires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Certificate:	4 Homicide determin			e, farm, str	eet, factory, office			Street and N wn, State)	umber or Rui	al Route Number,
Ω	ospita hours uneral	Medical	29a. Certifier 1 Certifying F	hysician: To the best of	my knowled	dge, death o	occurred at the time	e, date and pla	ace, and due to the d	cause(s) and i	manner as st	ated.
	the Hing 24 the Fi	Mec	only one) 3 Certifying	urse Practitioner: To the	e best of my	knowledge	death occurred at t	he time, date a	and place, and due to	the cause(s)	and manner a	
	Vith Vith Con		29b. Signature and title of certifier		10		29c. License	number	111	29d. Date s	igned (Month	n, Day, Year)
			17/	/ P	w		1 1/00	0057	14	Janu	The house	01 2017
			30. Name and address of person with Amy Schittman	MA DANI	eath (Item 2 Med 1	ca C	enter D	rive	rodcville,	, Ma	ylord	20850
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	MEN						
	Registr	_	JAN 3 0 20	14		4.0						
DHI	MH 17 Rev 06-	2011										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			➡ State Registrar	Cer	tificate of L	Death	Re	g. No. 2012	02016
- 1	Dhysicis	/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
Physician/ Medical Examiner			Williemae Aikens					4/ 2012	12:25p ^M
			4a. Facility Name (if not institution, give street and number)		,,,,	Location of Death		4c. County of Deat	
1			Stella Maris 5. Social Security Number 6. Sex 7. Agr	e (In yrs. last birthday)	Timoni If Under 1 Year	um If Under 24 Hrs.	8. Date of Birth	Balti	More thplace (State or Foreign
	Funeral Director		249-14-9160 Usual Residence of Decedent	95 Yrs.	Months Days	Hours Min.	(Month, Day, Y	'ear) Co	untry)
	land shov	tor	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Mary 28a-i otifie	Director	MD N/A	Baltimo					1 X Yes 2 ☐ No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 1510 Edison Highway		10f. Zip Code 212	13	10	USA	ountry?
р.ш.	r deatl	y Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent E Armed Forces? 1 □ Yes 2 ■	1	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	s afte ral", c	ed by	3 M Widowed 4 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🕱 No	Specify:		Specify: B	lack
:25	hour	Be Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occup	ation during most of working	1	6b. Kind of Business	/Industry
12:	in 72 he. " ran"	mo	Elementary/Secondary (0-12) College (1-4 or 5	i+) life. D	O NOT use retired)	Jaming Most of Workin	,g		
	d witl	Se C	12th N/A 17. Father's Name (First, Middle, Last)	Home	Maker	18. Mother's Name	(First Middle Ma	Private	
2012	be file ental + ked o ic eve	To	James Hudgins				State:		
JANUARY 24, 2012	should h and M 7 is mai traumat		19a. Informant's Name/Relationship (Type, Print)		-			City or Town, State, Zi	
7 2	and the alt		Sharon Anne Woods-Daugh 20a. Method of Disposition	20b. Place of Dispo	sition (Name of			e MD 21 20c. Location - City or	
JANUARY	age 1 ent of nt: If i		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 🏚 □ Other (Specify)	cemetery, cren	natory or other plac ill Cem	t. 2/1/	2012	Baltimor	e, MD
NA E	mit. P bartm sortai / injur		21. Signature of Funeral Service Licensee	22	. Name and Addre	i		1101 E.	
J	e a m e e		Dal Milk			timore,			
	Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition					t,	Approximate Interval Between Onset and Death
	Medical Examiner	ı	resulting in death) Due to (or as	a consequence of):					
	<u> </u>	dical Examiner	cause. Enter Underlying	a conse quence of:					
12	ate be executed physician and the burial-transit	xan	Cause (Disease or injury that initiated events c.	a consequence of):					
ENS	te be execut nysician and he burial-tra	la E	resulting in death) cast	a consequence e.,.					
KEN	phys s the	edic	d						
MAE AIK	e death c	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	elivery Day Year
WILLIEMAE	that th gned by	by Ph	Part II. Other significant conditions contributing to death b	out not resulting in the u	ınderlying cause gi	ven in Part I.		acco use contribute to	\checkmark
E S	equires eausigned brould b	ted						s 2 No 3 F	
Š	e law re has be	aldwo					24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
0	in: Th ifficate or, pa		25. Was case referred to medical		26. P	lace of Death (Check	1 Yes 2	X No 1 ⊔ Ye	s 2 No
÷	ysicia ysicia s cert	To Be	examiner? 1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursina Ho	me 5 Resider	nce 6 X Other (Spec	cify) HOSPICE
4	19 Ph ter thi		27. Manner of Death 28a. Date of inju 1 X Natural 5 ☐ Pending (Month, Da	y, Year) 28b. Time of injury	work	y at	28d. Describe hov		
2	the fu	ifica	2 Accident Investigation		M 1 🗆	Yes 2 No			
IIW	al or Att	Certificate:	4 Homicide determined 28e. Place of Injuries	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e only one) 3 X Certifying Nurse Practitioner: To the	xamination and/or inves	tigation, in my opini	on, death occurred at	the time, date and	I place, and due to the	cause(s) and manner stated.
	To th Withir To th	-	29b. Signature and title of contifier		29c. Licens			d. Date signed (Meni	
			12XIACACINF		1751	44742		1/25/2	1012
	2		30. Name and address of person who completed cause of o					t ,	
	2			DULANEY VAI	LLEY RD.	TIMONIUM	, MD 210	193	
	Sta	te	JAN 3 U ZUTZ /2 Hegistr	L. A.	West				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House at Satyr Hil Parkville Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day, Days 1 □ M 2 🖫 F Hours Min Mary Land 213-30-0601 **Director** Nov Usual Residence of Decedent or 28a-f show notified at 10b County 10a State 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director Parkville MD. Baltimore 1 Yes 2x No 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 21 Roger Valley Court 21234 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Research Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Η. Appell Naomi V. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles K. Askey/ Husband Roger Valley Ct. Parkville. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1-28-12 Towson. MD. Hilltop Service Co. 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Fureral Service Licenses York Rd. Towson, 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ations that caused the death cause on each line Approximate Interval Between Onset and Death To not enter the move of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death Other (specify) the a be detac signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed After this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Mydical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title Date signed (Month, Day, Year) 10 M of death (Item 23a) (Type, Print) Name and address experson who completed caus SCHREVE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year

State
Registrar

DHMH 17 Rev 06-2011

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

M Corneck

32. Registrar's Signature

12-00716

Print in Black Indelible Ink. Ensure All Copies Are Legible. Dennis Earl Atkinson State of Maryland / Department of Health and Mental Hygiene 2012 02019 Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 25, 2012 1236 hrs Madical Examiner Dennis Atkinson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Maryland General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country) NC Months Days Hours 05/25/1953 Director 237-92-1246 58 1X M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location E A 10a. State MD N/A 1 X Yes 2 No **Baltimore** Show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 IISA 1121 Punjab Dr. 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11 Marital Status the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No African Yes 1 Yes 2 X No specify: f Yes. Give Year Specify: American 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Robinson Be Samuel Atkinson traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ၉ 1121 Punjab Dr., Essex, MD 21221 Khadtjah Williams/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 02/04/12 Baltimore, MD Bayview Crematory Donation 5 Other Specify 5 22. Name and Address of Facility 21. Signature of F eral Se icensee Hari P. Close Funeral Service PA 5126 Belair Rd., Balto., MD 21206-5105 Approximate Interval 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transi Physician/Medical AMENDED UNPENDED The law requires that the death certificate be Records, P.O. Box 68760, 23d, Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Year 2 Fetal death Month past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by funeral director, page 2 should be detach 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital æ Other Nursing Home 5 Residence 6 Other 2 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification 1 V Natural 1 Yes 2 No 5 Pending death. within 24 hours after death To the Funeral Director: filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie January 31, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) State FEB 0 Registra

OCME

Patricia Aronica-Pollak MD.

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

12-00684	
Daniel Bassler	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

aniei Bassier		State of Maryland / Department of Hea			.No. 2012	2 0202
Physicia Aedical Exami	ın/	1. Decedent's Name (First, Middle,Last) Daniel Bassler		2. Date of Death Month January 24,		3. Time of Death 2317 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City	r, Town, or Location of Death	l	4c. County of Death Baltimore Cour	ntv
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur Mor	nder 1 Year If Under 24Hrs hths Days Hours Min		(MM/DD/YYYY) 9. Birth Foreign 30, 1964 ^{Cou}	pplace (State or
Aaryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Howard	Columbia			10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	Director	10e. Street and Number 5436 Harpers Farm Road	Zip Code 21044	100	. Citizen of What Count USA	ry?
or ite	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 No	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ White, etc.	te
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usu during most of v	ial Occupation (Give kind of vorking life. DO NOT use ret	ired)	16b. Kind of Business/In	dustry
e filed wall Hygie ced other	0	17. Father's Name (First, Middle, Last) Frederick William Bassler		e (First, Middle, Ma rginia B:		
Z = 6 2 2 1	٩	19a. Informant's Name/Relationship (Type, Print) (Parents) 19b. Mailing Addre Mr. & Mrs. Frederick Bassler 12792 I	ess (Street and Number or Linden Church	Rural Route Numb	er, City or Town, State,	MD 21029
Baltimore, MD 2 pernit. Pages I and 2 shou Department of Health and N Important: If Item 27 is n injury or other traumarte.		20a. Method of Disposition 1	emetery 1/2	27/2012	Fulton, M	D
Bal permi Depar Impo	Į	dhillia I Huch Moorich POI	nd Address of Facility HAZ Box 195_Sykes	11. M	0.01707	
Physician Medical Examiner	i	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Cardiovasc		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
_,		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
A.	Examiner	if any, leading to immediate cause. Enter Unorthing Couse (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):				
50, te be executed sysician and	ia E	d.	2025 3-21-	1.2 cm		
760, cate be ex physiciar he burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/A	23b. Was decedent pregnant in the past 12 months? 1			Month D	
P.O. es that the igned by be detach		Part II. Other significant conditions contributing to death but not resulting in the underty Schizophrenia	ing cause given in Part I.		acco use contribute to the 2 No 3 Proba	
cords law requi	Completed by			24a. Was ar autops perform 1 Yes 2	y prior to co ned? death?	opsy findings available ompletion of cause of S
Vital Rec ysician: The his certificate director, page	Ba	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check DOA Other Mursin	only one) ng Home 5 F	tesidence 6 Other:	
_ # . ^ # I	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division pital or Attendiours after death. teral Director: Affilled in by the fi	Certification:	3 Suicide 6 Could not be determined (Specify)	ory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur ate) (al Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 2 W Medical Examiner: On the best of my knowledge, death occurred at and manner stated.	the time, date and place, and my opinion, death occurred	d due to the cause at the time, date a	nd place, and due to the	cause(s)
	X	0-0-	O.C.M.E.		January 26, 2012	
arterd		 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. E 	Baltimore Street, Balti	more, MD 212	223	
St Regis	ate trar	31. Date filed (Month, Day, Year) JAN 3 0 2012 32. Registrar's Signature				
DHMH 17 Rev 1/2	001	OSME ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 201 Medical Flavius Hugh Brown 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 0 Date of Birth **Funeral** (Month, Day, Year) Director 220-36-2343 Usual Residence of Deced 1**X** M 2 □ F 74 10/12/1937 show 10a. State 10b. County 10c. City, Town or Location must be notified at Completed by Funeral Director 28a-f Maryland| Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n 23a with 801 Bengies Road 21220 Brown, Flaus , or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces? 1X Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machinist Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be Ellis Brown Julia Plumber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 <u> Eula Mae Brown (Wife)</u> 801 Bengies Road altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/31/2012 4 Donation 5 Other (Specify) Holly Hill Memorial Middle River, Maryland permit. 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month 4 Pregnant 9 Unknown Pregnant at time of death signed by the at Id be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4: ☐ Onknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an was a autopsy performed?
Yes 2 No has this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

a

Birthplace (State or Foreign Country)

West Virginia

Approximate Interval Between

Dav

2 🗌 No

1 Yes

Onset and Death

White

10d. Inside City Limits

1 ☐ Yes 2X No

Registrar DHMH 17 Rev 06-2011

State

inSquare Dr

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:15 Am Month Day Physician/ Burris William 4a. Facility Name (if not institution, give street and number) Emge Ro Medical **Examiner** Town, or Location of Death County of Death Cromupil Center Baltimor Saltimore MD 9. Birth State or Foreign **Funeral** Maryland Director Usual Residence of Decede 28a-f show 10a, State the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 XNo ö 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 23a 21774 items filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupatio (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked o မ George Burris Bradford Edna 19a. Informatic Name Belationship Type Prints ter Genesis Cromwell Center o. NSGT Address Squared Apples on Just Joute Justifes 6th at 185644 Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 M Other (Specify) state 21. Signature of Funeral Serv 22. Name and Address of Facility State Anatomy Board e Lice S Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. Medical resulting in death) Due to (or as _xaminer 6 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a co burialphysician Physician/Medical hosi P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day 5 Other (specify) Month Year Pregnant at time of death signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Co Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed plnods been 24b. Were autopsy findings available 24a. Was an page 2 autopsy prior to completion of cause of death? certificate has 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Ch = k only one) Hospital: Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 007 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who ven 31. Date filed (Month, Day, 32. Registrar's Signatu State 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 13:42P M January SR. BING, JOHN DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. Cheverly Prince Georges' Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Hours 1 📉M 2 🗆 F 578-20-0861 89 07/04/1922 South Carolina **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State notified at Director ¹¥ Yes 2 □ No Washington DC 10g. Citizen of What Country? 10f. Zip Code 9 10e, Street and Number iral", or items 23a o Examiner must be 23a Funeral should be filed within 72 hours after death with 20019 U.S.A. 368 Chaplin Street, S.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: If Yes. Give th and Mental Hygiene.
77 is marked other than "natural", traumatic event, the Medical Exa Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School 12th Maintenance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Louise Moore Arthur Bing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 368 Chaplin Street, SE;Washington, DC 20019 t of Health Fannie Bing (Wife) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Rock Hall Cemetery 1/29/12 Madison, Virginia 4 Donation 5 Dother (Specify) 21. Sign tun of Funer 22. Name and Address of Facility Freeman Funeral Services Beech Road; Temple Hills, MD 20748 4594 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or ach line.

Immediate cause (Final disease or conditions) Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** idem Esqueritally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 D No

9 Unknown Month Year 5 Other (specify) Pregnant at time of death been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 💢 FR/Outpatient 3 🗌 DOA ၉ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 28b. Time of Certificate: 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation I Director: A d in by the f 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a **To the Funeral D**completed filled i 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar 106 Irving

NW (NORTHTOWER)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Gerard Hams
31. Date filed (Month, Day, Year) -

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cerifi

29a. Certifier 1

29b. Signature and title of certifier

Medical

State Registra

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 00 M Muriel Bedford 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6 Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Min. Hours (Month, Day, Year) Country) 60 218-64**-**0555 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 500 North Denison Street 21229 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗷 No permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Specify: Black 3X Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4 or 5+) Administrative Specialist State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Harrid Geneva Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Denise Goodson-Sister 3600 West Franklin Street, Baltimore, any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 1/27/2012 Baltimore, 21. Signature of Funeral Service Licenses March F/H West a Wabash Ave, 4300 Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran Due to (or as a consequence of) that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? After this certificate 2 🗌 No Yes 2 . + 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific **Division of Vital** To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita ၉ 1 Yes 2 No 1 Hinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Date 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 ____atural 5 Pending 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined. Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. /Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 30. Name and address of person who completed caus 31. Date filed State Registrar

EDI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20Ĭ2 Stella Fave Broussard 5:00 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Elkridge 5741 Old Landing Road Howard Social Security Number If Under 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 216-32-3702 **Director** 1 🗆 M 2 🏝 F 76 June 24, 1935 North Carolina Usual Residence of Decedent 10a. State 10b County Director 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2xx No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5741 Old Landing Road 21075 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2x No Specify. Specify Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Baker Wedding Planner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Frnest E. Fox Leola Edmisten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Webster (Daughter) 5820 Timberview Drive Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Good Shepherd Cemetery Donation 5 Other (Specify) 1-27-2012 Ellicott City, Maryland Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEBILITY Physician/ disease or condition resulting in death) MONTHR Medical Due to (or as a consequence of): Examiner MONTHS DISEASE EREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner MENINGIOMA that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical YEARS EIZURE DISORDER IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant N/A 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year Unknown

To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: Division of Vital Records, P.O. Box 68760 this certificate has within 24 hours after death.

To the Funeral Director: After

r 28a-f show notified at

"natural", or items 23a or

Medical

the

death with the Maryland

filed within 72 hours after

Il Hygiene. other than "

Page 1 and 2 should be filed with truent of Health and Mental Hygier tant: If item 27 is marked other t jury or other traumatic event, th

Department or Important: If i any injury or or

Baltimore, Maryland 21215-0036

Part II. Other significant conditions of Hyperten.	ontributing to death but not resulting in the underlying cause given in Part I. $\!$	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Che	ck only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 X Residence 6 - Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? M 1 □ Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	1286 Place of Injury - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occurred se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place, and due to the cause(s) and manner stated

22832

01-25-2012

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) - --

5808 MAIN STREET, ELKRIDGE, MD 21075 M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene 2012 02027

ay Crego		State of Maryland / Department of Health and Menta 1- For State Certificate of Death Registrar		eg. No.	2 0202						
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month January 2	ath	3. Time of Death 1337 hrs						
TOUIS EXAMI	1101	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		4c. County of Death							
Funeral		Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24Hrs. 8 Date of Bi	rth(MM/DD/YYYY) 9. Bir	tholace (State or						
Director		141-78-1098 1 Months Days Hours		Foreig							
, any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
Maryland 28a-f show d at once.	tor	MD Harford Abingdon 10e. Street and Number 10f. Zip Code	14	l 0g. Citizen of What Cour	1 Yes 2 No						
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	3510 Thomas Point Ct. Apt. 1 C 21009	ľ	USA	iu y ?						
5-0036 led within 72 hours after death with the Maryland Hygiene. nther than "natural", ar items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongir 1 Naver Married 2 Married Armed Forces? 14 Yes, specify Cuban, Mexican, F		14. Race - Ameri White, etc.	can Indian, Black,						
after de al", nr i iner mu	by Fu	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	Cuban	Specify: CU							
2 hours "natur	ted !	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kinduring most of working life. DO NOT usual Occupation (Give kinduring most of working life. DO NOT usual Occupation (Give kinduring most of working life. DO NOT usual Occupation (Give kinduring most of working life. DO NOT usual Occupation (Give kinduring most of working life. DO NOT usual Occupation (Give kinduring most of working life.)		16b. Kind of Business/I Aberdeen							
5-0036 led within 72 hours after Bygiene. Inther than "natural", the Medical Examiner	Completed	12th Masters Deg. Software Engine		Grounds							
MD 21215-0036 d2 should be filed within 7 tht and Mental Hygiene. n 27 is marked nither than numatic event, the Medical	Be Co	Raydell F. Crego Hayde	Name (First, Middle, lee Caste	llanos							
imore, MD 2121; Pages I and 2 should be fil ment of Health and Mental B tant: If item 27 is marked or nither traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Tanya Crego-Wife 3510 Thomas Poi	er or Rural Route Nur	mber, City or Town, State	Jaon, MD						
2 2 2 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Location - City or	7 Own, State						
Baltimore, permit. Pages I as Department of Hes Important: If ite		4 Donation 5 Other Specify: EverGreen Cemetery			_						
Baltimo permit. Page Department of Important: injury ar ntt		21. Signature of Funeral Service Licensee 22. Name and Address of Facility North Ave. Ba		/H East 11 MD 21202	01 E.						
Physician Madical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.			Approximate Interval Between Onset and						
lxaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	by Mild I	Dehydration							
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60, ate be ex hysician e burial	Medical	IF FEMALE: AMENDED 23a-b, 27, per me, g924 2-23-1 23c. If yes, outcome of pregnancy	Z SIII	23d. Date of delivery							
Box 6876: death certificate the attending physic for use as the	cian/I		pregnancy		ay Year						
BOX he death y the atte	Physician/N	1 Yes 2 No 9 Unknown	I 220 Didte	obacco use contribute to	the eques of death?						
Division of Vital Records, P.O. Box 687(In the Hospital in Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phrompietely filled in by the funeral director, page 2 should be detached for use as the	á	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		s 2 No 3 Prob							
of Vital Records, by Physician: The law requirement this certificate has been some and director, page 2 should	ompleted		24a. Was autop	osy prior to c	topsy findings available ompletion of cause of						
ician: The la s certificate hi	ပ		1 ✓ Yes	rmed? death? 2 No 1 ✔ Ye	s 2 No						
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Division Islan Attendi Islan Attendi Islands death. Islands death. Islands death.	ertification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru	ral Route Number, City						
Divis ospital nr At hours after d uneral Direc iy filled in by	ပ	4 Homicide determined (Specify)									
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	e, and due to the caus urred at the time, date	and place, and due to the	e cause(s)						
	ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mor							
4		30. Name and address of person who completed cause of death (Item 23a)		1							
A	ote	Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore 31. Date find (Month, Day Year) 32. Registrar's Signature	e, MD 21223								
SI Regist	ate	TAND OF TOTAL									

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .Month ETHELYN MURIEL CASTELL 07:26.4M 2012 Medical anual y 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE CITY UNION MEMORIAL HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours **Director** 212-07-3369 1 □ M 2 🕅 F 1/30/1916 MARYLAND Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE TOWSON 1 ☐ Yes 2X No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1508 REGESTER AVENUE 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 12TH GRADE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ETHELYN M. SOMMERS F. GERDON WEBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EAST FRANKLEN STREET BALTIMORE, MD 21202 HENRY KLEMKOWSKI/ATTORNEY 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Xoremation 3 Removal from State 4 Domation 5 Other (Speoffy) 1/27/2012 CATONSVILLE, MD METRO CREMATORY, INC. 21. Signature of Funeral Service 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MQ1139 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. . First 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Vtach arres disease or condition Medical resulting in death) Examiner day Cardiac acrhythm19 Sequentially list conditions if any, leading to immediate Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 12 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation M 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie AT2438946 25. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

State

2012

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Timothy John Curran 2012 02029 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Lest) 2. Date of Death 3 Time of Death Physician/ Day 1614 hrs Medical Examiner January 26, 2012 Timothy John Curran 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Worcester Atlantic General Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Country)MD Davs Hours Director 213-92-0510 Nov.4, 1975 36 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No MD Worcester Ocean City Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at non-Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10900 Coastal Highway 21842 USA Funerai 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black. 1 Never Married 2 Married White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes White 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: à 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Night Manager Hilton Hotel 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Joseph Curran Margaret Willis B ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Burns Mother 1008 Grovehill Road-Halethorpe. MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2/3/2012 Atlantic Crematory 4 Donation 5 Other Specify: Glen Burnie, MD 22. Name and Address of FacilitySterling Ashton Schwab Witzke Luneral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville, MD 21228 21. Signature of Funeral Service Licensee M0/050 luma 23a. Pert I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Multiple drug intoxication involving oxycodone, /Medical Death Immediate Cause (Final disease a Fentanyl, Trazodone and Diphenhydramine **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g924 2-3-12 sm X UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth 2 Fetal death Year Month Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of has performed? ✓ Yes 2 No . death? 1 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 Other: this Yes After t 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Certification: 1 Natural subject took drugs 5 Pending 1 Yes 2 X No d in by the f after death. fd 1-26-12 fd 3:21 pm 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10900 Coastal Hgwy.

Apt 1109 Ocean City, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be (Specify) 4 Homicide Residence 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 27, 2012 Veed 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHWH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year)

<u>JAN 3 0 2012</u>

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Cullember Donna 2012 12:30AM 4a. Facility Name (if not institution, give street and number) 4c. County of Death Randallst OWY 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 58 6225 1 🗆 M 2 🖳 61 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 2122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ife. DO NOT use retired) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, -515te 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) orraine Your K 21. Signature of Funeral Service Licenses 22. Name and Address of Facility tween Death Year death?

Ph_sician/ Medical **Examiner**

Important: It any injury or once.

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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of Health and Mental Hygie item 27 is marked other other traumatic event, ti

notified

Funeral Director

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Completed

To Be

with the Maryland

permit, Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi

edical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Uisease or i that initiated events resulting in death) L
nysician/Medical	IF FEMALE: 23b. Was decedent pin the past 12 n 1 Yes 2 19 Unknown
Completed by Pl	Part II. Other signifi
Be	25. Was case referre examiner? 1 Yes 2 4
rtificate: To	27. Manner of Death 1 Natural 2 Naccident 3 Suicide 4 Homicide

Medical

5 Pending

Investigation 6 Could not be

determined

MSRWapame M.O

IY S Rajapakse, Mip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused the death. Do not enter the mode of dying, such as cardiac one cause on each line.	or respiratory arrest,		Approximate Interval Between				
Immediate Cause (Final disease or condition	lisease or condition							
resulting in death)	Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	1						
that initiated events resulting in death) Last	c. Due to (or as a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of de Month	olivery Day Year				
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death? Probably 4 \square Unknown				
		24a. Was an autopsy performed	prior to death?	rtopsy findings available completion of cause of s 2 No				
25. Was case referred to medical examiner?	26. Place of Death (Chec.		/ :	- Handles in a				
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital:	ome 5 🗆 Residence	6 Other (Spec	atient hospice				
	Long But of the Long Time of							

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0057465

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2503

28d. Describe how injury occurred

Baltimore MD 21209

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Unknown available

DHMH 17 Rev 06-2011

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2835 Smith AV

28b. Time of

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month SSIC Chinn 2012 M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Northwest Baltimore Dandallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days 1 M 2 XF 578-30-4382 Director May Washington DC Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1107 Silent Glade Road 21117 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black. White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ★Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked ot Jesse Chin Bessie Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Long (Daughter) 3600 Ely Place Se, Washington DC 20019 Baltimore, if item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 1/30/2012 Hanover, MD 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, Louing to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consecuence of The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: B 25. Was case referred to rpedical 26. Place of Death (Check only one) Hospital 2 1 10 Other: မ 1 Tes 1 Inpatient 2 DER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 3 Suicide 1 Yes 2 No the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and resugration, it may opinion, seath observed at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature 29d, Date signed (Month, Dav. Year) 006265 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vandal Istour MD 21137 010 court road 5401 (Jaib) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROY REGINALD Month 2012 2 Day 0308A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 233-64-6522 69 July 16, 1941 West Virginia **Director** Usual Residence of Decedent 28a-f show ms 23a or 28a-f shorms the notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5829 Harpers Farm Road 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian other traumatic event, the Medical Examiner ō ģ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Given 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: Black. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Business Administration Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H မ Mary Elizabeth Price Byrd Alexander Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is. Clarence W. Gough, Jr. (Son) 24 Musket Road Lincoln, RI 02865 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XX Cremation 3 Removal from State cemetery, crematory or other place, Atlantic Crematory 1-27-2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lidensee MD1050 22. Name and Address of Facility Witzke Funeral Homes, Inc. tuck 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BLEEDING GASTROINTESTINAL disease or condition resulting in death) da Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Suple up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Senhap

Registrar DHMH 17 Rev 7/2009

Box 68760

P.0.

Division of Vital

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	partment of Health and I e <i>rtificate of Death</i>		2111	2 02033				
		1. Decedent's Name (First, Middle, Last) 2. Date of Death									
	Physicia Medic		Roland Barry Dayhoff		Month January	Day Year 2012	2 3:37 P ^M				
1 - 1/4	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea					
-			515 Clear Ridge Rd. 5. Social Security Number 6. Sex 17. Age fin vrs. last birthda	Union Bridg	·	Carr					
и	Funeral Director		217 26 4600	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Bir (r) Co	thplace (State or Foreign nuntry)				
			Usual Residence of Decedent		July 21,1	1940 Ma	ıryland				
	land show	ģ	10a. State 10b. County 10c. City, Town or	_ocation			10d. Inside City Limits				
	Mary 28a-1 otifie	Director	Maryland Carroll	Union Bridge	9		1 ☐ Yes 2 🛣 No				
	h the	a D	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?				
	th wit	Funeral	515 Clear Ridge Rd.	21791		U	J.S.A.				
10	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	11. Marital Status 1 □ Never Married 2 🔀 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit					
21215-0036	s afteral",		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1963–65	1 🗌 Yes 2 🔀 No Specify:		Specify:	White				
2-0	hour hatu dical	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	, 16b	. Kind of Business					
2	nin 72 ne. shan ' e Me	oml	Elementary/Secondary (0-12) College (1-4 or 5+)	e kind of work done during most of work DO NOT use retired)	ang						
	led within Hygiene. other thar ent, the M	Be C	8	truck driver		transpor	tation				
Maryland	be filed ental Hyg ked oth ic event	To E	17. Father's Name (First, Middle, Last) Truman Joseph Dayhoff		ne (First, Middle, Maide	1					
Ž	should be file and Mental I is marked o raumatic eve				helma Irer						
	2 shouth and the shou		1	Closs Bidge Bd							
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Baltimore,	permit. Page Department of Important: If any injury or once.				rtzler Fur						
m	o a E c		Catharine V. Harles		Inion Bride						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.				Approximate Interval Between				
	hysician/	E 3	Immediate Cause (Final disease or condition	abia Infact	tho's		Onset and Death				
Target 1	Medical Examiner		resulting in death) Due to (or as a consequence of):								
		P.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	ed nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury			64					
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0	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	d.								
8760	ificate ig phy as th	Med	IF FEMALE:								
89 x	endir r use	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of de	livery				
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o.	at the d by t letack		Part II. Other significant conditions contributing to death but not resulting in the	Underlying cause given in Bort I	00. 5:41.1.	17.1.1	the cause of death?				
Division of Vital Records, P.O.	res th signe	d b	Strong Family Huston of				robably 4 Inknown				
ğ	requi been shoul	Completed	•				<u> </u>				
ecc	e law e has ige 2	g			24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of				
<u>=</u>	in: Th ificate or, ps		25. Was case referred to medical	OF Plans of Dorah (Observed)	1 Yes 2		2 No				
/ita	s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	26. Place of Death (Check							
of	g Phy er this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	ome 5 🔀 Residence 28d. Describe how inj		ify)				
o	endin eath. or: Aft he fur	ficat	1 Matural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No							
VİSİ	ir Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,				
Ö	urs af rral D		6								
	Hosp 24 ho Fune stely f	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation.	stigation, in my opinion, death occurred at	t the time date and place	ce and due to the	cause(s) and manner stated				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	e, death occurred at the time, date and pla 29c. License number	ace, and due to the cau	se(s) and manner a	s stated.				
	-> - 0		And we	D 4364		L-24					
		ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)							
		_	30. Name and address of person who completed cause of death (Item 23a) (Type,	Frederick St. T	THEUTOL	مس، سی	21787				
	Stat Registra	~ I	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,							
	negistra		JAN 3 0 2012 Regul D. Back								

DHMH 17 Rev 06-2011

Craig Emanual Davis, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02034
State of Maryland / Department of Health and Mental Hygiene

		Registrar			C	ertifica	ate of	Death					Reg. No.			
Physic Medical Exam				Cra	Davi	2. Date of Deat Month January 10				eath Day	Day Year		3. Time of Death 2115 hrs			
		4a. Facility Name (if not 713 Argonne D		ive street and nu	ımber)			b. City, Too Baltimo	vn, or Lo	ocation of	f Death	<u>·</u>	40	. County o	Death	
Funeral Director		5. Social Security Numb	20	,,,,					Months Days Hours Min.			1 _{Fo}			Foreign	1
		Usual Residence of Dec		21	- 4		IIS.				<u> </u>	11/2	19	70	COL	ntryMaryland
nd show any ice.		MD	. County		10c. C	ity, Town	or Locatio	on	Ba	ltim	ore	-		•	T	10d. Inside City Limits 1 X Yes 2 No
Aaryla 28a-f	Director	10e. Street and Number						10f. Zip C	ode				10g. Citi:	zen of Wha	nt Coun	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	eral Dir	713 Argor	nne Dri		edent Ever in	ue I	42.14/-	B		1212				US		
r death v or item	Fune	1 Never Married		Armed Fe	orces?		If Ye	s, specify (or Hispa Cuban, M	fexican, I	n? (Spec Puerto Ri	cify Yes or I can, etc.)	No-	14. Race - White,		an Indian, Black,
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21215-0036 wald be filed within 7 Mental Hygiene. marked other than	To Be	W1 L11 19a. Informant's Name/R	iam Dav			105	Mailia	A - -		J	oyce	Knig	ht			
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or tra		20a. Method of Disposition 1		Removal fro	20k	. Place of	Dispositi ry or othe	on (Name	of cemet	ery,		ate		ocation - C		
Baltimore, permit. Pages 1 a Department of He Important: If its		4 Donation 5 0	Other Specify	:	P	arkwo	ood	Cemet	_			/2012		altim		
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important: If item 27 is injury or other traumat		21. Signature of Funeral	- 0	timor	ره		22. Na 81	me and Ad 4 Ups	tress of shur	Facility of	Tri-	State	Fune	eral	Serv	rices, Inc. C 20011
Physician		23a. Part I. Enter the dise failure. List only one	ease, or comp	olications that ca		th. Do not	enter the	mode of d	ying, suc	ch as care	diac or re	spiratory a	rrest, sho	ck, or hear		Approximate Interval
/Medical Examiner		Immediate Cause (Final or condition resulting in c	disease a.	Head In			<u>ocia</u>	ted w	ith	Acut	te Al	coho]	Int	oxica	tie	n Death
	er	Sequentially list condition if any, leading to immedia		Dise to (or as a				·							_	/
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760, cate be ex physician he burial.	n/Medical	X UNPENDED		AMENDED			·i pe	r me	g924	4 2-	2–12 	vt ——				
		23b. Was decedent pregn. past 12 months?	ant in the	1 Live bi		2	Fetal	death	3E	Ectopic pi	regnancy			Date of de Month	livery Da	y Year
Records, P.O. Box 6. The law requires that the death cert cate has been signed by the attendit page 2 should be detached for use a	Physicia	1 Yes 2 No 9	Unknown	4 Pregna	nt at time of d wn	leath 5	=	r (Specify)								
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tal Rection: The		25 Was once setomed to			_							1 Yes	2 No		Yes	2 No
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of of ng Ph	일	1 ✓ Yes 2 N 27. Manner of Death	No	28a. Date o			ne of Inju		Injury at			I. Describe		ce 6 🗹	otner: 5	cene
Division ral or Attendi rs after death. al Director: A led in by the fi	Certification:	Natural 5 2 X Accident	Pending Investigation	61.	16-12	fd 8	3:57 ₁	om 1[Yes	2 X No	. s	ubjec	t fe	11		
Divis al or A s after al Dire	튀	3 Suicide 6	Could not be	28e. Place	of Injury - At h	nome, farm	n, street, f	actory, offi	ce buildi	ng, etc.	28f.	Location (Street and	d Number o		Route Number, City
bou hou y fil		4 Homicide 29a. Certifier 1 Certifie		(Opecany)	resid			-1.05-10		W.CHCLL		3 Arg	onne	_		timore, Md
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 Medic	cai Examiner:	an: To the best On the basis of and manner sta	examination a	and/orinve	occurred estigation	, in my opir	, date ai nion, dea	nd place, ath occun	, and due red at the	to the caus time, date	se(s) and and place	manner as e, and due	stated. to the c	ause(s)
	≥	29b. Signature and title of	fcertifier	11 0	~				ense nur							Day, Year)
	-	14 line	Grass		6			0.	C.M.E				Janua	ary 17, 2	012	
		30. Name and address of Melissa Brassell,		ompleted cause sistant Med			00 W. E	Baltimore	Stree	et, Balti	imore,	MD 2122	23			
Sta Registi		31. Date filed (Month, Day,	2012	32. Reg	istrar's Signati	ure	Kel									
				A Alice		-			_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3 mer 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore atonsville ommons mn 21228 If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday, **Funeral** Days Min. Hours 1XXM 2□ F **Director** 066-10-2878 98 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6348 Frederick Road 21228 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
No. 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1⊡Yes 2**√∑x**No ģ Specify: Specify: 3XWidowed 4 ☐ Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electrical $5\pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earle R. Elmer, Sr. Margaret Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6366 Forrest Avenue, Elkridge, Maryland 21075 Beverly Elmer - Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or c 1 → Buriat / 2 → Cremation 3 → Removal from State 4 Donation 5 Other (Specify) Maryland Vet. Cem. 02-02-2012 Owings Mills, MD 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signatu of Funeral Service Lice 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Eleter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** preumon disease or condition resulting in death) /Medical ue to (dr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off The law requires that the death certificate be executed physician ar s the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann eath 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier 1 🖰 Certifying PhysIclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 0 7 2 5 29d. Date signed (Month, Day, Year) and title of codifier 29b. Signaty

within 2

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

(Type, Print) Aviation B/ld Ste B Gles Burnia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Magodal ene 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Medical If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8 Date of Birth **Funeral** 4-314 Hours (Month, Day, Year) **Director** 1 🗆 M 2 🗗 F IRGINIA ia or 28a-f show be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Saltimore 10e. Street and Number 10g. Citizen of What Country? 23a Funeral "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) omes Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic eve ဂ 19a. Informant's ame/Relationship (Type, Print & RA 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) Green crest eron 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 cemetery, crematory or other pla Cremation 3 Removal from State -28-12 4 Donarion 5 Other (Specify) 21. Signatur of Funeral Source Linensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and one cause on each line. 23a. Part 1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Effusion disease or condition resulting in death) ural Medical Examiner ongestive Sequentially list conditions, Examiner as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypertension the burial-trar that initiated events the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) resulting in death) Last physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown P.0. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0067476 Baltimore Mi

Registrar DHMH 17 Rev 06-2011

State

Mercy

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State	State of N	/larylan		artment of H		d Mental Hy	/giene		
			Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Might 2049 2								012	3. Time of Death
ш	Physicia Medic		RUTH	ELC	VE	ER			Mich	~ 2°4 <	2012	1255 M
	Examin	er	4a. Facility Name (if not institution, g		m HOG	DIMAT	4b. City, Town, or		eath		y of Death TIMOR E	
-	Funeral		SEASONS HOSPICE 5. Social Security Number	5. Sex 7. A		ast birthday)	RANDALI If Under 1 Year Months Days	If Under 24 F Hours M		rth	Г.	ace (State or Foreign
	Director		219-16-4252 Usual Residence of Decedent	1 □ M 2 🖾 F		86 Yrs.	Worldis	1100/3	02/03/		Count	MD
	and s how dat	tor	10a. State 10b. County		10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Mary 28a-f	Director	MD BALTI	MORE	BA	LTIMOR						1 ☐ Yes 2 ሺ No
	/ith the 23a or st be r		10e. Street and Number 4204 OLD MILFO	סם זודא מס	ΛD		10f. Zip Code 21208			10g. Citizen of	What Countr	USA
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36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No No		Yes 2 No		erto Fricari, etc./	Specif	ck, White, et	
21215-0036	hours natura lical E	Completed	15. Decedent			16a. Deced	lent's Usual Occupa	ation		16b. Kind of I	WHIT:	
1218	within 72 giene. er than "i the Med	omp	(Specify only highes: Elementary/Secondary (0-12) 12	College (1-4 o	r 5+)		kind of work done d O NOT use retired)	0	vorking		TECA	т
	filed within al Hygiene. d other thai	Be	17. Father's Name (First, Middle, La	st)		<u> </u>	SECRE		Name (First, Middle	, Maiden Surnan	LEGA	.L.
/lan	should be file n and Mental H 7 is marked o raumatic eve	2	NATHAN FRANK SC	HONFELD				ESTH			BOGRA	D
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene with the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship			4						ode) RM #304
	I and 2 f Healti item 2 other I		SIGMAR ELOVER/ 20a. Method of Disposition	HUSBAND	20b. F	lace of Dispo	4 OLD MIL sition (Name of		Date	BALTIM 20c. Location		
imo			1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp				natory or other place OUNG MENS		/27/2012	BALT	IMORE,	MD
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service Lic	eusee			. Name and Addres				-	
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	cate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (or a	s a consequ	ience of):						
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x 687	ath certifics attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc	V		1	ate of deliver	
Вох	e death the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknow		death 5	Other (specify)	,		\ \ \ \	onth [Day Year
P.O.	or Attending Physician: The law requires that the death certificate be executed and death acted that the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	y Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to the	cause of death?
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E Re	iician: The certificate rector, pag		25. Was case referred to medical	1			26 Pla	ace of Death (C		formed?	1 Yes 2	P □ No
Vita	Physician: this certific al director,	To Be	examiner? 1 Yes 2	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	Othe	ir.	g Home 5 🗆 Res	idence 6XOt	her (Specify)	pio
n of	ding Ph h. After th funeral	ate:	27. Manner of Death 1 ▶ Natural 5 □ Pending		ijury Da <i>y, Year)</i>	28b. Time of injury	work'	rat ? Yes 2 □ No	28d. Describe	how injury occur	red	
isio	al or Attendir s after death. Il Director: Af ed in by the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could not determine	ot be 28e. Place of I	njury - At ho	me, farm, str	eet, factory, office	ies 2 🗆 No		(Street and Numi	ber or Rural F	Route Number,
Οį	ital or urs afte ral Dir lled in			building, t	etc. (Specify					wn, State)		
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check 2 Medical Ex	Physician: To the best aminer: On the basis or Nurse Practitioner: To	f examination	n and/or invest	tigation, in my opinio	n, death occurr	ed at the time, date	and place, and d	ue to the caus	se(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier			200	29c. License		2 10	29d. Date sign		
			Mely	on	<u></u>		W/3	0/	0	Vanz	5, 2	0/2
			30. Name and address of person w	no completed cause of	death (Item	DV1 4	de	Blood	Ofen.	Jan 2 Bura	p 2	106/
	Stat Registra		31. Date filed (Month, Day, Year)		trar's Signat	back	1					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10:15A Physician/ Fitzgerald Cynthia 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11 Stabilizer Drive Baltimore If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. (Month, Day Director 5-5-1961 171-56-3518 1 M 2 XF Japan 50 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 XIO MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral IISA 11 Stabilizer Drive 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status "natural", or iter dical Examiner Armed Forces?

1 Yes 2 Mo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White Yes. Give 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Medical Billing Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Larry Cornelison, Sr. Gail Cromwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10035 Fox Den Ct., Ellicott City, MD 21042 Pamela Doster - Sister permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other toonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Mt. CarmelUnited | 1-30-12 Orrtanna, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer Physician/ Cervical disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy for Month Day Year Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending injury after death.

Director: Af
d in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MsRajapahun.D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 703 N-5-Ray apakse, M.D. 2835 SmITh NV 5703 MD-21209. Baltimore

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	For State Registrar		State of N	/laryland		artment of F tificate of E			giene Reg. No. '	2012	2 0203
1/	1. Decedent's Name Norma		Last)					2. Date of Dea Month		Year 2012	3. Time of Death
al er			give street and number,	,		4b. City, Town, or	Location of Death			ounty of Deat	
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	Social Security N	umber 6		ige (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	g. Bir	thplace (State or Foreignuntry)
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Director	MD	Harfo	ord	Jop	na						1 ☐ Yes 2 🗶
חב	10e. Street and Nur		<u> </u>	1000	pu	10f. Zip Code		T	10g. Citize	en of What Co	ountry?
era	411 Jop	pa Far	rm Rd.			21085			US	A	
Funeral	11. Marital Status		12. Was Deceden Armed Forces			Vas Decedent of H			14	1. Race - Ame Black, Whit	
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De	17. Father's Name (First, Middle, La						ne (First, Middle,	Maiden Su	ımame)	-
2	Walter	L. Tay	lor				Helen H	Biggers			
	19a. Informant's Na	ame/Relationshi	ip (Type, Print)		19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or To	own, State, Zi	ip Code)
	Howard	J. Gri	er- Husb	and	411 J	oppa Fa	ırm Rd.	Joppa,	MD	21085	5
H	20a. Method of Disp		3 Removal from Sta	20b. Pl	ace of Dispo	sition (Name of natory or other place	ce)	Date		ation - City or	
ı		5 Other (Sp		" Gar		natory or other place Forest	1				ls, MD
ı	21. Signature of Fu	neral Service Lic	censee	\cap						st 11	01 E.Nor
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	shock, or hea	rt failure. List on	complications that cause only one cause on each I	ed the death ine.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between
	Immediate Cause disease or condition		_a wefa	SHILL		WVICA	1 can	cv			Onset and Death
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		1. Decedent's Name (First, Middle, Last)		Cer	incate or i	Jean		2. Date of Dea		£ 0	12	3. Time of	Death
Physicia Medic	al	Virginia Gay	Grah	am				January	/ 26	^y , 201	ľ2ª	12:3	0 рм
Examin	er	4a. Facility Name (if not institution, give street and number) 2525 Pot Spring Road, #K20	15		4b. City, Town, c		of Death		40	. County o	of Death timor	e	
Funeral Director			(In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Dat April 1	h X Year) 19			ace (State o	r Foreign
od at	_	Usual Residence of Decedent 10a. State 10b. County		Town or Loc	cation							d. Inside Ci	tv Limits
Marylar 28a-f sl	Funeral Director	MD Baltimore	,	Timon									2 X No
th the 3a or 2	ral Di	10e. Street and Number 2525 Pot Spring Rd., K-205			10f. Zip Code 210	03			10g. Ci	tizen of WI		ry?	
eath w	Fune	11. Marital Status 12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of F f Yes, specify Cubi		igin? (Spe	cify Yes or No-			- America	ın Indian,	
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12 shou lith and 27 is r r traun		19a. Informant's Name/Relationship (Type, Print) John Fox Graham-son			g Address (Street vy Reach								
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State	20b. Pla	ice of Dispo	sition (Name of natory or other pla			Date	20c. L	ocation - (City or Tov		
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permi Depar Impo any ir		21. Signature of Funeral Service Licensee William	G. Da	ıu ²²	. Name and Addre					mera 21204		ie, In	С.
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death.	Do not ente	er the mode of dyir	ng, such as	cardiac c	r respiratory ar	rest,			Approximat Interval Bet Onset and I	ween
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	conseque	nce of):	Lyno	DC	sen	St				Oriset and t	a A a a
Examiner	<u></u>	Sequentially list conditions, b.	YPI	ERT	ENSI	ON					(2	10 4	ethes
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ath certificate be attending physici I for use as the bu	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome o			Ectopic pregnan	cv				23d. Date	of delive	ry	
e death the att	Physician/Medica	in the past 12 months? 1 Yes 2 No 4 Pregnant at 9 Unknown			Other (specify) _	-,				Mon	th	Day `	Year
requires that the der been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to death bu	t not resul	ting in the u	nderlying cause gi	iven in Part	l.	23e. Did to	obacco	use contrit	oute to the	e cause of d	eath?
een sig	ed	CORONAR	7	1/19	78+>E							ably 4 🗌	
te law r e has b age 2 sl	Completed								osy rmed?	pr de	ior to con eath?	sy findings and pletion of c	available ause of
Physician: The la this certificate har al director, page		25. Was case referred to medical examiner?			26. P	lace of Dea	ath (C <i>h</i> ec	1 L Yes	2 6 N	0 1	Yes	2 LI No	
Physic this ce	욘	1 Ves 2 No Hospital: 1 Inpatie		R/Outpatier		4 LJ N		me 5 Resid					
ending Fath. er: After he funer	ficate	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident ☐ Investigation		injury	wor		- 1	Edd. Describe i	iow irijai	y occurred	.		
or Atte after de Directo in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, stre	eet, factory, office			28f. Location (5 City or Tow			or Rural	Route Numb	oer,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	29a. Certifier 1 Certifying Physician; To the best of n											
the Herithin 24 the Fu		(Check only one) 3 ☐ Medical Examiner: On the basis of exionly one) 3 ☐ Certifying Nurse Practitioner, To the	best of my	knowledge,	death occurred at	the time, da	ate and pla	the time, date a ice, and due to t	he cause	e, and due e(s) and ma ate signed	anner as s	ated.	inner stated.
MALL		I Joseph Vallar	M	0	De	205	769	0	77	WU!	12 Y	2-75	20/2
10 14.		30. Name and address of person who combleted cause of de		120	5 YO	rt	1/	20AD	, [UTHO	PRVI	UE	MP
Stat Registra	•	31. Date filed (Month, Day, Year) JAN 3 0 2012 32. Registral	s Signatu	8. 4	arkel								
				-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUAR 2012 Ann L. Gollaher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHAR MEDICAL PLA ENTE 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday, Funeral Days (Month, Day, Year) Dt 5, 1924 1 □ M 2 ₽ F Director 215-22-4987 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles Faulkner 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 9240 Timbercreek Lane 20632 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ¥ Widowed 4 □ Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Port of Baltimore Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Pearce William H. Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M. Gollaher 9240 Timbercreek Lane; Faulkner, MD 20632 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Amemation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Bosley UMC cemetery 2/1/2012 Sparks, MD 21. Signature of Funeral Services 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one cry Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prechant in the past 12 months? 1 — Yes 2 • No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Pregnant at time of death been signed by the should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Klaney disease 1 Yes 2 No 3 Probably 4 Unknown supreral vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours at To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Comparison of the cause of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) TCH FORE E 31. Date filed *(Month, Day, Year)*

DHMH 17 Rev 7/2009

State Registrar

M402

EP C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gabriella May Unth 27-20192 Hough 9:08 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Monthy Catonsville I'Ms il If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral PA Pac 1 □ M 2 🖫 F Days Min. Months Hours 6/18/1919 Director 94 168-05-9266 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 💢 No Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 XWidowed 4 ☐ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elizabeth Kellv permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Edward Schuster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Hough Bauer / Daughter 6615 Meeting House Road, Cumming, GA 30040 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Bayview Crematory 1/28/2012 Baltimore, Maryland Donation 5 🗆 Other (Specify) Signature of Funeral Service sicensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 215 osti 0.05 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Dus to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? bage, Hospital or Attending Physician: The certificate 2 No 2 - N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera Matural Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SS 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

Division of Vital

20, **HAMMEN** January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore NWSINGHOME

7. Age (In yes. last birthday)

97 Yrs. atoNSVI11e 10. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Securify Number 6. Sex **Funeral** 1□ M 2**E**F Days Min. Year) 212-03 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show "natural", or items 23a or 28a-f shov edical Examiner must be notified at Baltimore Director atons Ville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 222 USA Funeral CIVE 011228 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked out any injury or other contracts. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Newer Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: ۵ Specify: 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) leacHe Baltimore 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lomas ပ Katherine MANNION 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Hunter

6630 Robert Was Circle, (Catonsville, N. 19a. Informant's Name/Relationship (Type. Print) DAVE HAMMEN 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12012 Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 840ge END **Physician** Demis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner THOU KOPROVED BY CHEOTCAL EXAMINER The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): the attending physician hed for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) is been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by edeopos vos 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 -No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 4 varsing Home 5 Residence 6 Other (Specify) To 1 Yes 2000 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G923 1/30/2012 JH. State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 25 per me, g924,02/15/2012dhb
Registrar Reg. No. 2012

2. Date of Death

3. Time of Death

12:15P

10d. Inside City Limits

1 ☐¥Yes 2 ☐ No

MD21228

Approximate Interval Between Onset and Death

2WK

Day

Year

2012

Month

29d. Date signed (Month, Day, Year)

Birthplace (State or Foreign Country)

White

2012

1. Decedent's Name (First, Middle, Last)

NANCY

Physician

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only

EDM WUND

31. Date filed (Month)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical

State

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

34951

Below Cd out 100 Cotonor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jan 22, Physician/ 2012 1:15 A M Lee David Hersh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 188-32-4286 **Director** 1 X M 2 - F 07-05-1943 Pennsylvania 68 Usual Residence of Dec 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County at **Funeral Director** must be notified 1 Yes 2 X No Jessup MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a 20794 United States 7756 Sharewood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status "natural", or iten ledical Examiner n Black, White, etc. 1 X Yes 2 No 1961-If Yes, Give þ 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 1968 Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Department of Defense Analyst Be Maryland Department of Health and Mental Himportant: If item 27 is marked oth any injury or other traums***-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachel Ruth Walmer David James Hersh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7756 Sharewood Drive, Jessup, Maryland 20794 Donna K. Hersh - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Meadowridge Mem Park 01-28-2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at u e of Funeral Ser MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ malottic ue the (or as a subsequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): the burial-transi Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown tour Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 28c. Injury at work? 7. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 93

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0 2012

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State		State	of Mary	land /		rtment of		and M	1ental Hy	/gien	e	1.0	0001.5
		Registrar 1. Decedent's Name (/First. Middle.	Last)			Cen	tificate of	Death		2. Date of D	Reg. N	40. <u>U</u>	16	3. Time of Death
Physicia: Medic		Mary		Tinsley	/	Haw,	III				Januar		6 ^y , 20	ľ2°	5:00 a ^M
Examine		4a. Facility Name (if no						4b. City, Town,		of Death		4	lc. County o	of Death	20
Funeral		5. Social Security Nun		Greens [7. Age (ln)	yrs. last bii	rthday)	Timor		r 24 Hrs.	8. Date of Bi				lace (State or Foreign
Director		309-38-12		1 X M 2 \square F		75	Yrs.	Months Days	s Hours	Min.	Nov 1			Miss	ry)
nd how at	'n	Usual Residence of 10a. State	Decedent 10b. County		100	:. City, Tov	vn or Loc	ation			1101 1				Od. Inside City Limits
Maryla 8a-f s tified	rect	MD	Balt	imore		Ti	moni	um							1 🗌 Yes 2 🔀 No
h the l	al Di	10e. Street and Numb		roons Dr	ivo			10f. Zip Code	093			10g. (Citizen of W	hat Count	try?
ath wii	Funeral Director	11. Marital Status	- Jan G	12. Was Dec		n U.S.	13. W	as Decedent of		rigin? (Spe	ecify Yes or No	_		S.A.	an Indian
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 Never Married 3 Widowed 4		Armed Fe	orces? 2 💢 No ve		If	Yes, specify Cul	ban, Mexica	n, Puerto	Rican, etc.)			k, White, e	etc.
2 hour	plet		15. Decedent	's Education t grade completed	zi)	16	a. Decede	ent's Usual Occu	upation e during mos	st of worki	ing	16b.	Kind of Bu	siness/Ind	lustry
rithin 7 iene. r than the M	Completed	Elementary/Secon	dary (0-12)	College (1-4 or 5+)		ACCO	ind of work done NOT use retired unting	& Busi Admini	ness	tion	1	Accour	nting	
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uld be I Ment narked natic e	욘	Marvin			w, Jr.					ildre				hroe	
nd 2 shoresealth and m 27 is not traum		19a. Informant's Nam Ellen R.	Haw-wi					Suburb							21093
Page 1 a ment of H ant: If ite ury or ott		20a. Method of Dispo 1 ☐ Burial 2 🗙 4 ☐ Donation 5	Cremation	3 Removal from	n State P	Ob. Place of the competer of t	of Dispos ery, crem Op S	ition (Name of atory or other place) erv. Co	rp.		Date 1/12		Location -		wn, St <i>a</i> te
permit. Departn Importa any injt		21. Signature of Fune	eral Service Li	censee Will	iam G.	. Dau		Name and Addi					unera 21204		me, Inc.
Physician/ Medical		23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List or	ily one cause on e	ach line.		not enter	the mode of dy	ring, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Chset and Death
Examiner				Due to	(or as a con	sequence	of): = [[c4	Cardin	Z						Years
_ #	iner	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate	b. Due to	(or as a con	sequence	of):	- t							(
cate be executed physician and s the burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) La	jury	c. Due to	(or as a con	sequence	of):							-	
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tificate ng phy e as th		IF FEMALE:													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans.	by Physician/M	23b. Was decedent print the past 12 mg 1 Yes 2 9 Unknown	onths?		Birth 2 🗆 gnant at time	Fetal dea		Ectopic pregna Other (specify)	ncy				23d. Date Mon	e of delive th	ry Day Year
requires that the des been signed by the s should be detached	y Ph	Part II. Other signific	ant condition	ns contributing to	death but no	t resulting	in the ur	iderlying cause (given in P art	t I.	23e. Did	tobacco	use contri	bute to the	e cause of death?
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To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check 2	Medical Ex	Physician: To the laminer: On the batter. Nurse Practitione	sis of examir	nation and/	or investi	gation, in my opii	nion, death o	occurred at	the time, date	and place	ce, and due	to the cau	se(s) and manner state
10 W		29b. Signature and tit	1	Det -) / (7	041		29d. D	ate signed	(Month, D)ay, Year)), 20(2
10 14		30. Name and address	s of person w		se of death	(Item 23 <i>a</i>)	(Type, Pr	YORK	RUAS	0 1	UTHER	بارد	e M	19 ;	21093
State Registra		31. Date filed (Month,	Day, Year)	2012	legistrar's S	ignature	he	12)							

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. D2012 22 5:30 A M Carol Jean Hoover Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore <u>Stella Maris</u> Timonium Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 219-60-2857 **Director** 1 🗆 M 2 🔀 F 59 Feb. 3, 1952 Maryland 28a-f show 10a State 10b. County must be notified at 10c. City, Town or Location Director 1 Yes 2 X No SD Union Beresford 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 401 Sunset Drive 57004 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner 9 Yes 2X No þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
any injury or other traumatic event, the Medical Exa 1 Yes 2X No Specify Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stanley Goss Carlyn E. Tormellon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Goss/Brother Lutherville, Maryland 21093 1022 Jamieson Road 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State onation 3 I Formation 3 I Formation 5 I Other (Specify) ANUARY 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 2/4/12 Baltimore, Maryland 21. Signatur 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the dises shock, or heart failure 23a. Part or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence or, Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: CAROL HOOVER 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) for Pregnant at time of death Month Day Year been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 👿 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes Other: 욘 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 TOther (Specify) HOSPICE funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea. ral Director: After 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide within 24 hours after des To the Funeral Director completely filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 29d. Date signed (Month. Day, Year) person who completed cause of death (Item 23a) (Type, Print)

State Registrar JACKIE

JONES

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 11:45A M DIANE HOLSEY 201 1 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GEORGE'S MORE NURSING HOME HYATTSVILLE THOMAS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗵 F Days 5//31/1949 WASHTNGTON,DC Director 218-54-9297 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland must be notified at Director PRINCE GEORGE' HYATTSVILLE MD 1 X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4922 LASALLE AVE 20782 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK "natural", 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DMINISTRATIVE ASSISTANT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES GREEN ROSA GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is <u>JAMES HOLSEY/SON</u> 48th Baltimore, PL NE WASHINGTON N D C 20019 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of i
Important: If it
any injury or o 1 Durial 2 Cremation 3 Removal from State HARMONY MEM. CEM. 4 ☐ Donation 5 ☐ Other (Specify) 2/2/2012 LANDOVER 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service Lice 1425 MARYLAND AVE NE WASHINGTON. DC20002 23a. Part 1. Enter the dileast, or complications that caused the de. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faill re. list only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Uterine disease or condition metastatic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory Failure / Ventilator Dependent Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? End Stage Reval Disease / Hemodialysis 24a. Was an autopsy Encephalopatho Yes 2 No 1 Yes 2 by No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury n 24 hours after war e Funeral Director. Af 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the same 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) JANUARY 20 2012 185

State Registrar DHMH 17 Rev 7/2009 4203 Queenshury Rd Hyattsville MD 2078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRE

31. Date filed (Month, Day, Year)

MI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9925 3-22-12 yt. State of Maryland / Department of Realth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Physician/ Month 03:15 AM Anna Mary Kishner Anna Mary Kusher Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Aug 23, Days Hours Min Country) Maryland 1923 **Director** 217-14-2187 88 Usual Residence of Decedent show or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1065 Craftswood Road 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed ForcesX 1 Pes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ے filed with... خوا Hygiene. خو**r than "r** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien 7 is marked other th banking officer banking industry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oscar Winnberg Margaret Mayo Department of Health an Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 682; Williamsport, MD 21795 Dianna Kilham - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 Other (Specify) Ronal d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 1 alexa disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a concequence cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed HABKI that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending plants to the design the second the second to the second the se IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown signed by t Id be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No 1 🗌 Yes Yes 2 No 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ပ Impatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 0 0 60 3 9 6 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MURSHED

3 0 2012

31. Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g924 2-3-12 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Kenneth J. Carev Day Physician/ Month Year 20,2012 hauam Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center

5. Social Security Number [6. Sex _ 17. Age (In yrs. last birth purnie If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Hours Min (Month, Day, Year) 215-40-9632 1 👿 M 2 🗆 F 70 Director 30 194 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits must be notified at 10c. City, Town or Location Director Maryland 1 🗌 Yes 2 🗓 No Odenton Anne Arundel 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? items 23a 21113 USA 8213 Redmiles Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Dorothy Bennett Paul James Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8213 Redmiles Lane, Odenton, Maryland 21113 Michael E. Carey - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park 01/24/2012 Elkridge, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 7250 Washington, Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or opmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List oph one cause on each line Onset and Death Immediate Cause (Final Pnysician/ 5 colomic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Examin Hospital or Attending Physician: The law requires that the death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of) -burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 g Unknown ed by the a detached f q Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed page 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 00551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hosptial Drive, Glen Burnie, Maryland 21065 Tsion Berhane

State Registrar 31. Date filed (Mont

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Kelly Jacqueline 6'.45A M 2012 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Seasons Hospice Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 213-28-9785 Hours Min. Country 1 🗆 M 2 🖵 F Director 82 05/07/1929 New York Usual Residence of Deced show of Health and Mental Hygiene. it item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1x Yes 2 □ No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 Mt. Royal Ave. Apt 313 21217 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 \square Never Married 2 \square Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 ➡Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Baltimore Sports (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4 or 5+) Laborer Wear permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James N. Smith Bertha A. Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Moore(daughter) 709 Adana Rd., Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 \square Cremation 3 \square Removal from State on-site Crematory () 4 Donation 5 Other (Specify) 27/12 Baltimore, MD 21. Signature of Funeral Service Licenses Fosephadas of Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician. Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of in that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Day Year Pregnant at time of death signed by the a the Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 24 hours after death.

Funeral Director. After this certificate letely filled in by the funeral director, pag 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Other: ျ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause of the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nskygpameM.D DOUS7465 1/26/12

DHMH 17 Rev 06-2011

State Registrar 212091

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. ROYDAKK M.D. 2835 J. M.M. SV SZOB BAH MONE

5832

N.S. Rayapakse, M.D.

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kenneth 1711 PM entzner 0 6106 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Maryland Medical Cente Baltimore 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Hours Director 213-38-8235 1 X M 2 □ F 71 7, Maryland or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Maryland Carroll Union Bridge ŏ 10e. Street and Number ms 23a or must be r 10g. Citizen of What Country? Funeral 430 Bucher John Rd. 21791 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) roads department/ I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the county government <u>equipment operator</u> of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ <u>Sterling Walter Lentzner</u> Emma Caroline Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia S. Lentzner/ wife 430 Bucher John Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Johnsville Meth. Cem: 1/27/2012 Johnsville, MD 22. Name and Address of Facility Hartzler Funeral Home Signature of Funeral Service Licen Tar 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Inforction 5 days Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Director: After this certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: ပ 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MD 1063737518 1/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Baltimore, MD 21201 22 sovah Ciccotto 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January ^{Day} 24. 2012 Elizabeth M. McNally 8:30AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sun Valley Assisted Living Carrol1 Westminster 5. Social Security Number . Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Months Feb. 2, 1920 Hours Country) Director 163-18-4693 Yrs Usual Residence of Decedent 23a or 28a-f shov 10a, State at 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified 1 Yes 2 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4115 Ridge Road 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F 9 John Marlin Sarah McGinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 621 Green Valley Way Eldersburg, MD 21784 Mrs. Susan Bunting (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Jan. 28, 2012 Cheltenham, PA 4 ☐ Donation 5 ☐ Other (Specify) Sepulchre Cem. Signature of Funeral Service License ^{22. Name and Address of Facility} HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complicator's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between n et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mentia Due to (as a Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of, Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 ☐ Probably 4 ☐ Unknown ficate has been sig r, page 2 should b Completed 1 Tes 24b. Were autopsy findings available 24a Was an has autopsy performed prior to completion of cause of death? certificate 2 🗆 No 2 1 🔲 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes မ 159isted 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 \square Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director. At completed filled in by the fu death. 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D00581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 25. Wayne William McCullough, Sr. 2012 12:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19 Shady Nook Avenue. Apt Catonsville Baltimore **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Hours Maryland 9/16/1954 Director 214-64-5004 Yrs. 54 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must handless. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Shady Nook Avenue, Apt 2 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Meat Manager Retail Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Anthony McCullough Evelyn Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Wayne William McCullough, Jr. 907 Southridge Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 1/28/2012 Baltimore, Maryland g at ve of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lie Interval Between Immediate Cause (Final Onset and Dea Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 should 1 ☐ Yes 2 ⚠No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an has autopsy page perform certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Tyes 2 **N**o Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of ce License number

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the backers of Completed by Division Medical Control Continuous Medical Completed by Division Medical Control	completed by Filysiciall/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			rth 2 ☐ Fetal nt at time of d wn		Ectopic pregn Other (specify					Month	Day	Year
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IHV	3	30. Name and address of pe	rson who com	TRA	mBB	23a) (Type, Pri	nt) VAI +	105P1	TAL	OF	BA	LTIM	ORE	
State Registrar	3	30. Name and address of pe	3"0 201	2 32 Regi	istrar's Signatu	1. pa	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 27° 2012^{Year} Physician/ 12:33 PM January Malcolm A. Myers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Sex 1X M 2 □ F Maryland Hours Min. (Month, Day, Year) an 5, 1930 Jan_ Director 82 214-26-8659 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 🔯 No Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21087 12001 Stoney Batter Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Canton Railroad 12 Trainman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Virginia Sies Leroy McKinley Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Stoney Batter Road; Kingsville, MD 21087 Tonna J. Thomas / daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 1/31/2012 Towson, MD 1 Other (Specify) 4 Donation 1050 York Road Signature of Funeral Survive 22. Name and Address of Facility 25 Towson, MD 21204 Ruck Towson Funeral Home, Inc. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one, Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SCHOOVIC Lars Medical he to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician الله والمعالمة المعالمة hysician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPUG မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural After work? 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST TOWSON MID CHALLES

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ January 26, 20°12 12:30 A M Mynar Frances Emily Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Towson Manor Care of Towson Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 09-16-1925 Maryland 86 219-22-5209 Director 1 🗆 M 2 🗶 F Usual Residence of Deced ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Baltimore N/A 1 Yes 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA Funeral 1 and 2 should be filed within 72 hours after death with in the lath and Mental Hygiene.
item 27 is marked other than "natural", or items 23a 4819 Carmella Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Examiner Black, White, etc. 1 X Never Married 2 Married Completed by 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Secretary Elementary/Secondary (0-12) College (1-4 or 5+) Bank of America Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Zitnik Anna Emi 1 Mynar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4819 Carmella Drive Baltimore, Maryland 21227 19a. Informant's Name/Relationship (Type, Print) 4819 Carmella Drive Mrs. Therese Dolbow - Great Niece 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cemetery 01-31-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) FA eral Service Licensee 22. Name and Address of Facility 5305 Harford Road 21. Signature Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Interval Between Onset and Death Physiciani disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to for as a consequence of, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached to Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1.No certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural s after death.

I Director: After in by the further. 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day/Year) 29b. Signature and title of certifier 29c. License number 350 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV 0 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ 0630 AM LAWRENCE Ε. MOTEN JR. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Hours (Month, Day, Year) **Director** 578-64-4709 1 XM 2 - F 62 3/17/1949 WASHINGTON, DC 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Y Yes 2 □ No HYATTSVILLE MD PRINCE GEORGE' 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4915 EASTERN AVE HNITED STATES 20782 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ LAWRENCE E. MOTEN SR. EMMA FREEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sit Department of Health ar Important: If item 27 is any injury or other trac LAUREN EDWARDS/DAUGHTER 5606 PLAID DRIVE LAUREL MD. 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State FT. 1/31/2012 BRENTWOOD, MD LINCOLN CEM. 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service 1425 MARYLAND AVE NE WASH.. DC 20002 complications that caused the death. Of not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician a SEVERE MALNUTRITION disease or condition Medical resulting in death) Examiner METASTATIC COLON CANCEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last buria attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death n signed by the a ld be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2**x** No 1 XInpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 XNatural work?
1 Yes 2 No 5 Pending e Funeral Director: Af oletely filled in by the fu М Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number D0067279 30. Name and address of person who completed cause of deat 1/25/2012 (Type, Print) 1500 SUGANTHI ALAGARSAMY FOREST GLEN RD. SILVER SPRING 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 JAMES JOSEPH MANGAN 7:33 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDRICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 079-26-3837 1 🛛 M 2 🗆 F **Director** Yrs 77 Jan. 2, 1935 New York Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 1 Yes 2 X No Union Bridge Maryland Frederick 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? with Funeral U.S.A. 11929 Beaver Dam Rd. 21791 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. ò 2 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1956–68 1 Yes 2 XNo Specify "natural" White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 4 police officer county government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked ot Ir other traumatic ever မ James Mangan Mary Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : 11929 Beaver Dam Rd. Union Bridge, MD 21791 Nancy Harmon/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State injury or Department of Important; If any injury or MD Veterans Cemetery 1/30/2012 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sig viury of Funeral Service Licer apparene New Windsor, MD 21776 Box 249 P.O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Myltiorson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the at d be detached for g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No page 2 has 24 hours after death.

Funeral Director; After this certificate Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier 1🔨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.D 23/ 2045 Secrets 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	ate of Marylan	•				and Me	ental Hyg	giene	0.10	00050
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate	OT D	eatn			Reg. No.	1117	UZUDS
	Physicia	n/								2. Date of Dea Month Januar y		2012	3. Time of Death 3:20 AM
	Medic		Jack Delphy McKinney 4a. Facility Name (if not institution, give street a.)			4b. City, To	own or l	ocation of		Dalluary		Inty of Death	3.20 121
	Examin	er	Carroll Hospital Cent					ster	Death			roll	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under	1 Year	If Under 2		8. Date of Birth	1	9. Birth	place (State or Foreign
	Director		219-20-4721 1XM2	□ F 82	Yrs.	Months	Days	Hours	Min.	(Month, Day	23,192	29 Cour Ma	aryland
ī	d ow t	L	Usual Residence of Decedent 10a. State 10b. County	100 00	, Town or Loc	action							10d. Inside City Limits
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	or 28s	Director	Maryland Carroll 10e. Street and Number	0	nion E	10f. Zip				Т	10a Citizen	of What Cou	
	with th	ıral	111 Lightner St.				2179	1			USA		,
	eath v	Funeral	11. Marital Status 12. Wa	as Decedent Ever in U.S		Vas Decede	nt of His	panic Origi	in? (Speci	fy Yes or No-		Race - Americ	can Indian,
9	fter de , or it	by		ned Forces? ☑ Yes 2 ☐ No res, Give		Yes, specif			Puerto Ri	can, etc.)	- 1 -	Black, White,	
	ursal tural" al Exa	Completed	3 Awidowed 4 Divorced Yea	ar or Dates. 1948 -	-52	□ Yes 2	Y 1100	эресну:			Spe	^{cify:} Whi	ite
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7	ithin ene. r thar	Con	Elementary/Seconday (0-12) Col	llege (1-4 or 5+)		O NOT use i Y tru	,	lriver	r		Cen	nent Co).
O O	led w Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)		Quali	y cru				First, Middle, I			
an	l be fi lental rked tic ev	입	Charles Emory McKinne	∋y				Mary	y Car	oline :	Delphy	7	
Maryland 21215-0036	hould and N is ma		19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailir	g Address (Street an	nd Number	r or Rural i	Route Number	City or Tow	n, State, Zip	Code)
	nd 2 sealth nn 27		Sandra Rigler/daughte	er	14 5	. Far	quha	r St.	. Uni	on Bri	dge, M	1D 2179	91
Baltimore,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Remov		lace of Dispo emetery, cren	sition (Name natory or oth	e of her place))	Da	te	20c. Locati	on - City or To	own, State
Ē	t. Page 1 tment of tant: If it jury or o		4 ☐ Donation M☐ Other (Specify)		Count					2012	Sykes	ville	, MD
ga	permit. Page 1 Department of I Important: If it any injury or or once.		21. Signature of Full All Service Licens e		10.00	. Name and			naı	tzler			
			23a. Part 1. Enter the disease, or complication	is that caused the death		E. B				n Brid	-	2179	Approximate
٠,			shock, or heart failure. List only one cause Immediate Cause (Final				H	1			,		Interval Between Oz et and Death
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	Examiner					S 6		Κ.					
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	cuted nd ransi	xam	Cause (Disease or linjury that initiated events c										
	certificate be executed anding physician and use as the burial-transit	alE	resulting in death) Last	Oue to (or as a consequ	ence of):								
3	ate b physie the b	edical	d										
200	ding se as	W/C	IF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnar	ncy _						23d	. Date of deliv	verv
ROX	death o	Physician/M	in the past 12 months?	☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of d		Ectopic pr Other (spe					1 200.	Month	Day Year
о п	the d	hys	g Unknown	Unknown									
7.	requires that the death certifica been signed by the attending p should be detached for use as t	by F	Part II. Other significant conditions contributi	ng to death but not resu	ulting in the u	nderlying ca	ause give	n in Part I.	•				he cause of death?
gy,	requires been significations									1 🗆 ነ	res 2	lo 3 ∐ Pro	bably 4 🗆 Unknown
Vital Records,	law re	Completed								24a. Was a autop	sy	prior to co	psy findings available empletion of cause of
T T	Physician: The law this certificate has al director, page 2 s	Con								1 Yes	med? 2 No	death?	2 No
<u>ta</u>	ician: certifi ector	Be	25. Was case referred to medical examiner?				26. Plac	ce of Death					
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Z C	nding th. : After	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	M I	work?	 ′es 2 □ 1	- 1	a. Besonbo ii	ow injury co.	Jarrod	
DIVISION	or Attending Physician: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At ho		eet, factory,	office		2			mber or Rura	l Route Number,
<u>≥</u>	tal or rs afte al Din ed in			building, etc. (Specify)	,					City or Tow	n, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: 7 (Check 2 Medical Examiner: On										
	thin 2 the f	Me	only one) 3 Certifying Nurse Pract			death occurr		time, date a		and due to the	e cause(s) and	d manner as s	tated.
-	7 № 0		29b. Signature and title of certifier	44.0			_		2 ~			gned (Month,	
	,		30. Name and address of person who complete	ed cause of death (Item	23a) (Type =	Print)	100	181	7 /		1/18	112	
			wilbur Kus 29		Aug 5	F30	7	W45	tanin	ster	MI	21	157
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure			. /			· -		
	Registra	ır	IAN 2 0 2012 /2	4 . 2. 484									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2

		•	State Registrar	Ce	rtificate of L			giene Reg. No. 🤈 🦳	2 02060
	Physicia Medic		Decedent's Name (First, Middle, Last) Abdc	olhamid Moghl	bel		2. Date of Dea	26 ^{Pay} 201	3. Time of Death 2:25 P M
	Examin		4a. Facility Name (if not institution, give street and num 455 Jonathan Street	nber)	4b. City, Town, or Hagers	Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 194–62–5162 1 ☑ M 2 ☐ F	7. Age (In yrs. last birthday) 58 Yrs.		If Under 24 Hrs. Hours Min.	8, Date of Birtl (Month, Day 06/02/	h 9.	Birthplace (State or Foreign Country) Tran
	Maryland 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD Washington	10c. City, Town or Lo	Hage	rstown			10d. Inside City Limits ※✓ Yes 2 ☐ No
	with the s 23a or ust be r	Funeral D	10e. Street and Number 455 Jonathan Street		10f. Zip Code 2	1740		10g. Citizen of Wha	
980	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎖 Divorced 12. Was Dece Armed Fo 1 □ Yes If Yes, Giv Year or Da	2 🗶 No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No		ecify Yes or No- o Rican, etc.)	Black, V	American Indian, Vhite, etc. White
21215-0036	within 72 hou giene. e r than "natu the Medica l	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-12th	-4 or 5+) (Give life. L	edent's Usual Occup: e kind of work done o DO NOT use retired)	during most of wor	king	16b. Kind of Busin	
Maryland 2	d be filed v Mental Hyg arked othe itic event,	To Be	17. Father's Name (First, Middle, Last) Morteva Moghbel		J IXAIY ME	18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	
	and 2 should Health and M em 27 is mar ther traumati		19a. Informant's Name/Relationship (Type, Print) Hannah Moghbel (Daugh		ing Address (Street a				
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other	3 .5	20a. Method of Disposition 1 □ Burial 2 ☎ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State 20b. Place of Dispo cemetery, cre. Ardent Co	ematory or other plac	^{e)} 1/28	Date 3/2012	20c. Location - City Hanove:	
Balt	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licenses		22. Name and Addres				rvices,PA e MD 21224
	Control of the process of the private process of the private of th	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	(or as a consequence of): (or as a consequence of):	0				Approximate Interval Between Onset and Death
. Box 68/60	death certif e attending ed for use a	Physician/Medical	in the past 12 months?	nant at time of death 5	☐ Ectopic pregnanc☐ Other (specify)	ry		23d. Date o Month	f delivery Day Year
as, P.O	law requires that the nas been signed by the s 2 should be detach	þ	Part II. Other significant conditions contributing to d	eath but not resulting in the	underlying cause giv	ren in Part I.		_	te to the cause of death?
2	The law ate has page 2	Completed					24a. Was a autop perfor 1 Yes	sy prior	e autopsy findings available to completion of cause of th? Yes 2
Vital	ding Physician; The h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	Othe	ace of Death <i>(Ched</i> er: 4 Nursing H		ence 6 🗆 Other (S	specify)
on 01	nding Pł ath. r: After the ie funeral	Certificate:	2 Accident Investigation	of injury th, Day, Year) 28b. Time o injury	work		28d. Describe ho	ow injury occurred	
DIVISI	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,			of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office		28f. Location (St City or Town		r Rural Route Number,
	ກ e Hosp in 24 hou ກ e Fune pleted fil	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the base only one) Certifying Nurse Practioner:	sis of examination and/or inves	stigation, in my opinic	on, death occurred a	at the time, date ar	nd place, and due to	the cause(s) and manner stated.
D	To t with To t	_	29b. Signature and title of certifier		29c. License	8995	2	29d. Date signed (M.)	onth, Day, Year)
			30. Name and address of person who completed caus Yong Tong, with a state of the s	e of death (Item 23a) (Type, I	Print) Haft	Istown,	MD	21740	1
í	Stat Registra		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	Kel				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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an Du	VIG IVIOD	1	- For State eqistrar	tificate of Death	Reg. No.
F	hysicia	_	. Decedent's Name (First, Middle,Lest)		2. Date of Death Month Day Year January 28, 2012 3. Time of Death 0054 hrs
	Exami	ner	Brian David <u>McDevitt</u>		
			a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Anne Arundel
			Fort Smallwood Road and Devere Drive	Pasadena	
F	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	■ IForeign
D	irector		218-15-8380 1 ⋈ м 2□F 32	Yrs.	11/26/1979 Country)Maryland
		į	Jsual Residence of Decedent		10d. Inside City Limits
	7 209		10a. State 10b. County 10c. City,	Town or Location	1 Yes 2 No
7	shoy	5		sadena	10a. Citizen of What Country?
3	or 28a-f show fied at once.	ect	10e. Street and Number	10f. Zip Code	10g. Citizen of what Country?
t,	23a or 28a-f sho	百	7796 Tick Neck Road	21122	pecify Yes or No- 14. Race - American Indian, Black,
4	De od	Funeral Director	11. Marital Status 12. Was Decedent Ever in U. 1. Marital Status 12. Was Decedent Ever in U. 1. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 	
3	or ite	S	1 Yes 2 No		Specify: White
ę	ral",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of	
	tygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)
စ္တ	lical	ple		Custodian	Anne Arundel Co School
8	giene Biene	Completed	12 N/A 17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Maiden Surname)
21215-0036	R S H	0	David R. McDevitt	JoAnn	D. Foreacre
212	Mental H marked c eveot,	O B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
, MD 21215-0036	and 2 should be filed within 2. Health and Mental Hygiene. item 27 is marked other than r traumatic eveot, the Medical		Joann D. McDevitt (Mother)	7796 Tick Neck Road	Pasadena, Maryland 21122
e)	Healt item		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore,	permit. Fages 1 and 2 s Department of Health as Important: If item 27 injury or other traums		1 X Burial 2 Cremation 3 Removal from State	len Haven Mem. Pk. 02	/04/2012 Glen Burnie, Marylan
. <u>.</u>	artme	1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Funeral Home, P.A.
ã	permit. Departm Import injury		The I belling	3204 Mountain Roa	Funeral Home, P.A. d Pasadena, Maryland 21122
h	ysician		23a. Par Inter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac	
	Medical aminer		Immediate Cause (Final disease a. Head and chest injuries	S	Death
EA	aiiiiiici	'	or condition resulting in death) Due to (or as a consequence of	of):	
		_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of):	
		miner	cause. Enter Underlying Cause		
	sit	1 10	events resulting in death) Last Due to (or as a consequence of	of):	
Records, P.O. Box 68760,	eath certificate be executed eattending physician and for use as the burial - transit	le H	d amended		
oʻ.	be ex sician surial	Medical	Oliverious Contraction		23d. Date of delivery
92	ficate g phy s the b	Ž	IF FEMALE: 23c. If yes, outcome of preg 23b. Was decedent pregnant in the 1	gnancy 2 Fetal death 3 Ectopic pregi	5 V-44
89	endin use a	Physician/	past 12 months?	~	
ĝ	e death the att ed for	Ş	1 Yes 2 No 9 Unknown 9 Unknown		23e. Did tobacco use contribute to the cause of death?
Ö	that the ned by t detache		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	1 Yes 2 ✓ No 3 Probably 4 Unknown
σ.	requires that th been signed by hould be detach	d b			
흔	w requir s been s should	Completed			autopsy prior to completion of cause of
္တ	e law e has ge 2 sl	Ē			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
8	The lificate h		25. Was case referred to medical	26 Place of Death (Chec	k only one)
/ita	hysician: The this certificate I director, page	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nurs	sing Home 5 Residence 6 🗹 Other: Scene
Division of Vital Records,	tending Physician: eath. oor: After this certifi the funeral director,	⊢	27 Manner of Death 28a, Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Driver auto auto collision
5	ath.	5	1 Natural 5 Pending Jan 28, 2012	0046 hrs 1 Yes 2 ✓ No	
<u>:8</u>	r Atto ter de irecto n by t	<u>ខ</u> ្	2 V Accident Investigation 3 Suicide 6 Could not be 28e, Place of Injury - At	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) Fort Smallwood Road and Devere Drive, Pasadena, M
á	urs af	Certification:	4 Homicide determined (Specify) Local Stre		
	Hosp 24 ho Fuoc rely fi		29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as stated.
	To the Hospital or Attendity within 24 hours after death. To the Fuoeral Director: / completely filled in by the fi	Medical	and manner stated.		d at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	= s = s	≊	29b. Signature and title of certifier	29c. License number	January 28, 2012
			(a (u) 1/1/1	O.C.M.E.	January 20, 2012
			30. Name and address of person who completed cause of death the	m 23a)	o MD 21223
				900 W. Baltimore Street, Baltimor	6, IVID 2 1220
		State	31. Date filed (Month, Day Year) 2012 32. Jegistrar's Signa	turg parket	- A 41-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Norma June Norman January 8:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Transitions Health Care Sykesville Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min $12^{M_{P,n}th,\,Pay,\,Year)}$ Mary Land 219-12-5021 87 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Carrol1 Sykesville 1 Yes 2 No Md. 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 407 Piney Run Court 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates Mental Hygiene.
marked other than "natura 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12yrs. University Hospital College (1-4 or 5+) Secretary marked other t Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Harvey Riley Lydia Zwangzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4812 Sykesville Rd. Sykesville, Md. 21784. Linda Powder(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View 01/28/2012 Sykesville, Md. 21. Signature of Fune of rvice cense ^{22. Name and Address of Facility} Haight Funeral Home & Chapel Box 195 Sykesville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or in that initiated events for use as the burial-tran s been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death g Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy performe page 2 death? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 454 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Tes 2 500 မ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury **1**→ Natural 5 Pending 2 🗆 No Accident Investigation thin 24 hours after deat the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by Homicide determined City or Town, State) Medical 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signature ar title of certific 29d. Date signed (Month, Day, Year) (2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 \right For State Registrar Certificate of Death t's Name (First, Middle, Last) 2. Date of Death Physician/ 7:10 AM oore bonuary. Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Grove lar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Director 9 1 □ M 2 🔽 -18-1913 show 10c. City, Town or Location at 10d. Inside City Limits Director notified Ballimore 28a-f MD 1 Yes 2 ☐ No 10e. Street and Number o 10g. Citizen of What Country? r items 23a or iner must be r Funeral 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? 2 No Completed by 1 Never Married 2 Married ō ☐ Yes 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. "natural", 3 ₩idowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) uith and Mental Hygiene. 27 is marked other than "i r traumatic event, the Med Secondary (0-12) College (1-4 or 5+) are Be Maryland ည 430 Toplar of Health of item 27 i Treston Grove! other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 등 1 Burial 2 Cremation 3 Removal from State = 6 Baltimore Department or Important: If any injury or once. 2-2-12 anonal: 4 Donation 5 Other (Specify) 21. Signature of Funeral Servicense nss CEROBreene Funeral Jat' 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ementa Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the t Box 68760 IF FEMALE: detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ putension 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available 24a. Was an cate has t autopsy performed prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 📝 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate; 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ڡۣ Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 NOVTH CHAYLES State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2 Date of Death itkowski Tanuary Physician/ 00 Inomas vew Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner och Kaven Community Living Forest If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of L... (Month, Day,) 1 M 2 F Days Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item. 7 any injury or other traumatic arrest. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗖 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 801 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. VICTNAM Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-ASKLON F rade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. rulmona Onset and Death Immediate Cause (Final struct Physician/ MYONIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de ? Certificate: To Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence To the Funeral Director: After thi completed filled in by the funeral 27. Manur of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 900

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Battim

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M

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Wicks

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 9 per fh g924 2-2-12 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25 Day Month Juanita Navarro 20°T2 10:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death North Arundel Health & Rehab Glen Burnie Anne Arundel . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 219-88-5737 81 **Director** 1 □ M 2 🛂 F Vrs 3-19-1930 Phillipines Usual Residence of Decedent 28a-f show at 10c. City. Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? be ns 23a Funeral 1234 Cathedral Drive 21060 USA ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian "natural", 3 Widowed 4 X Divorced Completed Department of Health and Mental Hygiene. Input Impurant: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Owner 12 Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Juan Catalan Adelaida Alvarez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Stonewheel Court E. Millersville MD 21108 Nover Navarro/sno 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/28/2012 Glen Burnie MD Glen Haven Cemetery 21. Signature of Fun, al Se vice Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MYM Medical resulting in death) **Examiner** Sequentially list conditions, Examine Jule to for all a do transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Récords, P.O. Box 68760 the as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Dav Pregnant at time of death 1 Yes 2 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No Yes 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work 1 Yes 2 No Investigation Accident □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Detifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 2 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) Name and address of person who completed cause Grain Mwy Sw Glan

Registrar DHMH 17 Rev 06-2011

State

12-00776 Corbin Daniel O'l	Brie		se Type o State	of Maryla	nd / D	k indelib epartmel	nt of ⊢	lealth and	Menta	al Hy	giene	gible		my 5 i	0 0006
		1- For State Registrar				Certificat	te of D	eath			, R	Reg. No.	4		
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Funeral		Henryton Roa 5. Social Security Nur		ex T	7. Age (In	yrs. last birtho		If Under 1 Year		24Hrs.	8. Date of B				place (State or
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be ootified at once.		13374 Gri	nstead (Ct.				21784				USA			
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5-00; ed with fygienc other t	팅	17. Father's Name (F									First, Middle,				
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Should and Martic ematic	ဥ	Kevin O'B						Grinste							
e, N 1 and 2 Health Fitem 3		20a. Method of Dispo		Domewal fr		20b. Place of cremator	Disposition	on (Name of cer	metery,		Date	20c.	Location -	City or 1	Town, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be sotified at once.	L J	21. Signature of Fund	eral Service Licer	rsee			22. Nan	ne and Address	of Facility	Hai	ght Fu	nera	al Ho	me 8	Chapel
Physician		23a. Part I. Enter the	disease, or comp	olications that c	aused the	death. Do not	enter the	mode of dying,	such as ca	rdiac or	respiratory a	rrest, sh	ock, or hea	art .	Approximate Interval Between Onset and
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6876 ertificat ding ph	an/Med	23b. Was decedent popular past 12 months?		1 Live b		2	=	death 3	Ectopic	pregnar	псу		Month	D	ay Year
Box 68760, e death certificate be the attending physic ed for use as the burned for use	Physici	1 Yes 2 No	9 Unknow	- L		5 or dealing	Othe	r (Specify)					_		
b.O. E that the d ned by the detached	by Ph	Part II. Other signific	cant conditions	contributing to	o death bu	t not resulting	in the und	derlying cause	given in Par	rt I.		_	✓ No 3		the cause of death?
ords, P. w requires th	ted h						-				24a. Wa		24b. V	Vere au	topsy findings available
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Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2	No	Hospital: 1	Inpatient		tpatient]		Home 5				: Scene
n of Viding Physi		27. Manner of Death	5 Pending	28a. Date (Monti	of Injury h, Day,Year)	28b. T	ime of Inju	1 1	ry at Work? Yes 2 🗶		^{28d.} Describ subjec	t i			haust fume
ivisior or Attendather death Director:	icati	2 Accident	Investiga	28e Plac	<u>-27-1</u> ce of Injury	- At home, far	6:10 rm, street,	factory, office	building, etc	3.		(Street			ral Route Number, City
Divisior - Hospital or Attenc 24 hours after death - Fuoeral Director: stely filled in by the	Certification:	3 X Suicide 4 Homicide	6 Could no determine	ed (Specify)		ound i					<u>Marrio</u>	tsv		<u>Md.</u>	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fuperal Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.		(Oncon only	Certifying Physic Medical Examine	cian: To the be	st of my kn	nowledge, dea ation and/or in	ith occurre	ed at the time, d n, in my opinio	ate and pla	ice, and curred a	due to the ca t the time, da	iuse(s) a te and p	and manne blace, and c	r as state lue to th	ed. e cause(s)
To the within To the comp	Medical	one) 2 ✓ 29b. Signature and t		and manner		IRR	Q.	29c. Licen							nth, Day, Year)
	-	(3)/10/3	\$60/	Ula -	1/2/26	1	5~	O.C.	M.E.			Ja	nuary 28	3, 2012	2
1	1	30. Name and addre		completed cau	use of deat	h (Item 23a)	000.11	Daltim '	Otront D	altine -	ro MD 24	223			
Ψ		Victor Weed		Assistant Me				Baitimore	oreet, Ba	aitimo	- WID ZT	223			
S Regis	tate trar			Bener	U B	Signature	Kar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Osborne Physician/ 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Kitche 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Numbe **Funeral** Hours Min Country -56-6590 **Director** 1 □ M 2 🗙 F 68 Yrs 20 V 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director 1 X Yes 2 No TIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be n Funeral USA THOVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Was Deceden 2. Armed Forces?

1 Yes 2 No nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or iten
or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Keswick Home Be Baltimore, Maryland Maiden Surname) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, ဂ္ဂ avior Par honia 19a. Informant's Name/Relationship (Type, Jeffer y Osbo) Rural Route Number, City or Town, State, Zip Code) - Son 1103 1timore, 21216 $M \cap$ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 1/2012 Balto, Department Important: If any injury or 21224 MD 4 ☐ Donation 5 ☐ Other (Specify) F/H-East 1101 E. North ire of Funeral Service Licens 22. Name and Address of Facility 1tmore MD Enter the disease, or complications that cause (th. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death late Cause (Final immer late Cause (FI disease or condition Physician/ 3 MONTHS EZ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 Yes 2 No Month Day 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □ Unknown BRAIN METASTASES 1 Yes 2 No Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No/ 24a. Was an autopsy has page 2 certificate filled in by the funeral director, 25. Was case referred to medical Vital 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other HOSPICE 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury, - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On th Certifying Nurse Practiti 29d. Date/signed (Month, Day, Year) 29b. Signature 01/26/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCE MP ZIZIO HOROWITZ State Registrar

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12-00741 Joice Price Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 02068

		1- For State Registrar	Certificate o				
Physicia		Decedent's Name (First, Middle,Last) JOICE LEVINE PRICE			2. Date of Death Month	Dav Year	3. Time of Death 1906 hrs
Medical Exami	ner	4a. Facility Name (if not institution, give street and r	number)	4b. City, Town, or Location of D	January 25 Death	4c. County of Death	
		Johns Hopkins Hospital		Baltimore		BALTIMOR	E CITY
Funeral Director		5. Social Security Number 6. Sex 231+28-8838 1 M 2 F	7. Age (In yrs. last birthday) 82 Yr	If Under 1 Year If Under 2	4Hrs. 8. Date of Birth Min. 0ct. 18	(MM/DD/YYYY) 9. Birt 3,1929 Foreig Col	
eny.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	tion			10d. Inside City Limits
and show	ŏ	Maryland Baltimore City		Baltimore	City		1 X Yes 2 No
death with the Maryland or items 23s or 28s-f she must be notified at once	Director	10e. Street and Number 5603 Knell Avenue		10f. Zip Code 21206	10	g. Citizen of What Cour USA	ntry?
nd 240215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examingr must be notified at once	Funeral		Forces? If	as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu Yes 2 No specify:		14. Race - Ameri White, etc.	ite
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215-0036 be filed within 72 hours ntal Hygiene. rked other than "natur ent, the Medical Exam	Completed	8 yrs. College N/A	(1-4 or 5+)	nost of working life. DO NOT use ture Store Mana		Farber Fu	rniture
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212 ould be I Menta mark	To Be	Norwood Price 19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number		per, City or Town, State,	
MD id 2 sho lith and in 27 is		Kevin A. Price (Son)		5 Marlboro Rd.			
		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal	from State crematory or o		Date	20c. Location - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:		Forest V, A. 2	2-2-2012	Owings Mil	
Ba perm Depa Impo	1	Cotto Hospe (7401 Belair Rd.	Lassahn F Baltimor	uneral Home e, Md. 2123	6
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	caused the death. Do not enter	the mode of dying, such as card	iac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple In	juries a consequence of):				Death
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	iner	if any, leading to immediate Due to (or as cause. Enter Underlying Cause	a consequence of):				l i
cuted nd transit	l Examiner	(Lisease or injuly that initiated events resulting in death) Last Due to (or as d.	a consequence of):				
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Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	mont at time of death	etal death 3 Ectopic protection ther (Specify)	egnancy	23d. Date of delivery Month D	ay Year
that the dened by the			to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to	_
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Division of Vital Records, talor Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should	Completed				24a. Was en autops perform	y prior to c ned? death?	topsy findings available completion of cause of s
tal Rectan: The certificate ector, page	Bec	25. Was case referred to medical examiner? Hospital:		26.Place of Death (Ch			
n of Vital ding Physiclan: h. : After this certif: stuneral director,	리	1 ✓ Yes 2 No	Inpatient 2 ✓ ER/Outpatien e of Injury 28b. Time of		ursing Home 5 R	Residence 6 Other	
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Suicide Could not be	ce of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rui ate) ad, Baltimore, MD	al Route Number, City
e Hosp 24 hou e Fune etely fi		29a. Certifier 1 Certifying Physician: To the be					
To th withir To th	Medical	one) 2 Medical Examiner: On the basis and manner 29b. Signature and title of certifier		29c. License number	ieu ai ine time, date a	29d. Date signed (Mon	
		Light Cult		O.C.M.E.		January 26, 2012	
2	ŀ	30. Name and address of person who completed car					
DX\		.4 4 -411	miner 900 W. Baltimo	re Street, Baltimore, MD	21223		
St Regist	ate	31. Date filed (Month, Day, Year) 2012 32.	egistrar's Signature	Mil			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8:10 AM Physician/ 2012 27 Catherine Potee Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & Rehab Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Birthpic Country) MD **Funeral** Months 1 🗆 M 2 🗓 F Days Hours Min 4-20-1926 213-20-2953 85 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location the Maryland Director notified 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? ö must be 23a Funeral with 7355 Furnace Branch Rd E. 21060 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. 6 q 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify white Specify: "natural" 3 X Widowed 4 Divorced Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the switchboard operator communications 10 Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be in ment of Health and Menta Charles Williams Elva (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 N. Jerome Pkwy Glen Burnie MD 21060 Darlene Thedans/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metro Crematory 1 Buria 2 X Cremation 3 Removal from State 1/28/2012 Catonsville MD Other (Specify) → Donation 22. Name and Address of Facility Kirkley-Ruddick Funeral Home M01364 421 Crain Hwy SE Glen Burnie MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 page 2 s certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 ¥ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred After 5 Pending injury 1 X Natural ieral Director; A Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 [

State Registrar

Signature and title of cer

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

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29c. License number

51596

7845 Oakwood Royd Glen Burnie MD 21061

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a Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:35 A M JANUARY 26, MARGOT RUSSEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SUNRISE ASSISTED LIVING ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) 9. Birtholace (State or Foreign Funeral Months Days Country) GERMANY 1 - M 2X F Hours Min 0771071920 Yrs 215-28-9128 91 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2X No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 6208 MEADOW COURT 20852 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 KWidowed 4 Divorced Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER AUTOMOBILE ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of

traumatic ever 2 NASS ULLMANN JENNY UNKNOWN ISSAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER RUSSEL/DAUGHTER 6208 MEADOW COURT, ROCKVILLE, MD20852 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHEVRA AHAVAS CHESED 01/27/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Lo 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ADVANCED DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) HYPERTENSION and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) LIVING မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After X Natural injury 5 Pending Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a, Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

604 S. FREDERICK AVENUE, SUITE 409, GAITHERSBURG, MD 20877

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

M.D.,

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ATTAN KASID,

31. Date filed (Month, Day, Yea

26,2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JaMuary 23°; 2012° 7:05 A M Glenn Seaman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Townson 5. Social Security Number If Under **Funeral** 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 👿 M 2 🗆 F Months Hours 09-19-1950 **Director** Maryland 215-56-5034 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Cockeysville 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #6-G Deepwater Court 21030 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married 1968 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify. Completed 1968 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Security Company marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Meni Important: If tem 27 is marke any injury or other traumatic tonce. Benjamin Seaman traumatic Sylvia Garbis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Y. Seaman - wife #6-G Deepwater Court, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1XXBurial ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem. 01-27-2012 Owings Mill, MD 4 Donation 5 Other (Specify) Signa 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nonic CP2Wncms disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 23 2012

State Registrar

DHMH 17 Rev 7/2009

N. Charles

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Katherine Elizabeth Schatz 6:42 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Halethorpe Baltimore 3226 Magnolia Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 57 Director 214-64-8878 1 □ M 2 🗶 F New York Jan 13,1955 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 No Halethorpe MD Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21227 3226 Magnolia Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 XMarried 2XXNo Completed by Yes Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Equipment Credit Manager other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gibson Mc Aulay မ Elizabeth Ann Hodges permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halethorpe, Maryland 21227 3226 Magnolia Avenue Thomas C. Schatz (Husband) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 1/26/12 Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Inc. 21. Signat 7250 Washington Blvd. Elkridge, Maryland 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, if any account to a cause. Enter Underlying Cause (Disease or injury that initiated events Examine and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician ar s the burial-t resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 27 9 Unknown been signed by the a a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perfor death? 1 Yes 2 No __ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify ပ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 038762 01-23-12 son who completed cause of death (Item 23a) (Type, Print) Sharon 30. Name and address of persons of persons of the second o

State Registrar

31. Date filed (Month, Day, Year

32. Registrar's Signature

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARI 03D Medical 4a. Facility Name (if not institution. 4c. County of Death **Examiner** 24 Hrs. Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 48 11-29-1963 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ✓ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Yes, specify Cuban , Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Date Specify 3 🗌 Widowed 4 🗀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) + Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a, Informant's Name/Relationship (Type, Print) ral Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 4 Neck disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Dav should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform Yes 2 No certificate 2 No 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 240 1 Inpatient 2 ER/Outpatient □ Nursing Home 5 □ Residence 6 ② Other (Specify) Nursing Home 5 □ Residence 6 ② Other (Specify) s after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Date signed (Month, Day, Year) 2012 23a) (Type, Print) on who completed cause of death (Item AMUAPIRUS my 2140 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2104 P Jamuary 25^{ay} 2012^{ar} Gordon T. Smitheman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 - F Months 4 73 7 19 43 ar New Jersey Director 68 151-34-6788 Usual Residence of Decedent or 28a-f shov "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland 1 🗆 Yes 2 🙀 No Harford Forest Hill 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 21050 U.S.A. 2143 Mardic Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify: White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Data Technology Section Chief injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ပ permit. Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or com Marguerite Marion Forester Sydney Arthur Smitheman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2143 Mardic Drive Forest Hill, Maryland 21050 Eric G. Smitheman / Son Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State 2/3/2012 Towson, Maryland Hilltop Serv. Corp 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the 1 ☐ Yes ∠ L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1/2 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifie 🏒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 26,

Registrar

DHMH 17 Rev 7/2009

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e of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Betty Juanita Sullivan 2012 12:46P ^M 26, January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Sykesville Transitions Health Care If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth
(Month, Day, Year)
April 26,1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 218-26-8855 **Director** 1 🗆 M 2 🔀 F 82 Kentucky Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2400 Neudecker Road 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 🖁 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Transportation School Bus Driver should be filed with hand Mental Hygien 7 is marked other th event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Molsner William Joseph Johnson traumatic 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2445 Bollinger Mill Road; Finksburg, MD 21048 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Charles R. Brown, Jr.-Grandson Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Springfield Cemetery 2/1/2012 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Huneral Service Licen Funeral Home of Catonsville, Inc. 21228 1630 Edmondson Avenue: Catonsville Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE END STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Date to for as a nonsequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami executed Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 2 To the F OM

257722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENETREE RUAD # 300 PIKESVILLE MD 21208 CEONARD RICHAMSON M.D. 31. Date filed (Month.

3

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title

🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2012

JANUARY 27

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan a 26 Physician/ Shifflett Suzan 2012 2:33 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crownsville 1042 Dockser Drive If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 216-50-5437 1 □ M 2**XX**F Aug. 24,1947 Pennsylvania 64 Usual Residence of Decedent show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Crownsville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 United States 1042 Dockser Drive death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes, Give 1 and 2 should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Hote1 Management event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic ever ٩ Charles_Hartenstine Rebecca Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21032 Mr. Randy M. Shifflett(Husband) 1042 Dockser Drive Crownsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 1/28/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 21. Signature of Funeral Service Lic 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) poglycemio Medical Examiner Dicibe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown ate has been signed by the a page 2 should be detached Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 🗌 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify this filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pendina Accident Investigation s after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D completely filled i Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and the of certified

31. Date filed (Month, Day, Year) 1AN 3 0 2012

Sullivan

M.D.

32. Registrar's lignatur

116 Defense Highway, Suite 400

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

072375

01, 27, 2012

Annapolis, MD 2 1401

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANUAR Thelma Shewbridge Mae Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death EN BURNIE WASHINGTON MEDICAL (If Under 24 Hrs. Birthplace (State or Foreig Country) **Funeral** Days Director 218-16-2872 1 🗆 M 2 🗷 F May 27,1922 Maryland or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 23a 8450 Lyndale Avenue 21122 U.S.A should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Admission Analysis Univ. of Delaware 12 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mae Watson Eva William Hansel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Robert E. Shewbridge (Son) 927 Rustling Oaks Drive Millersville. Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Cremation 01/27/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P 3204 Mountain Road Pasadena, Mar 23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death MYDLAR Physician/ DIAL INFAPETION disease or condition Medical resulting in death) Examiner ME Sequentially list conditions, Examiner frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 724b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has balinector, page 2 s autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}}\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Death 27. Man 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending s after death.

I Director: Af
d in by the fu 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours af Euneral Dietely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

complet only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Name and address of person who completed cluse of death (Item 23a) (Type, HOS State egistrar's Sigr Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Frederick Trickett Jr. 2012 8:30p January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2728 Deer Park Road Finksburg Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 219-64-8032 1 XM 2 - F Feb 1 1955 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Carrol1 Finksburg 1 🗌 Yes 2 🛣 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2728 Deer Park Road 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 💢 No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 X Divorced Year or Dates is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Md Dept of Environment environmental specialist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Frederick Trickett Sr. Eva June Wilson 27 is marked r traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Benjamin R. Trickett (son) 14 View Trail, Fairfield, PA 17320 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🛣 Cremation 3 🗎 Removal from State emetery, crematory or other place) All County Cremation 1-27-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses erbert € total along the P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nset and Death) Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** COVONOVY Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna
Pregnant at time of death 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Vear the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After the Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutheruille Ó 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19^{Day} Trim Willimena 9:00p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Bluepoint Nursing Home Social Security Number 8. Date of Birth
(Month, Day, Year) Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2X□ F Trinidad Director 214-72-8389 Usual Residence of Decedent should be filed within 72 hours after death with the Maryiand and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 5719 Winner Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade Shirt Factory Seamstress na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Brenette Trim Farrell Burkely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a item 27 is 5719 Winner Ave, Baltimore, Md 21215 Phyllis Hoyte-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge 1/27/2012 Pikesville, Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Marchand Address of Facility. 4300 Wabash Ave, 21215 Baltimore, Md 23a. I in 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure to Thome Physician/ Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Congestine Hart failure and I-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day ed by the a detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☑ No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospita or Attending 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 V Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and fitter of certifier

State Registrar

Box 68760

P.O.

whang

31. Date filed (Month, Day,

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMIT BUVTANI 821 N

072536

EUTAN STREET Ballmore MD

12-00815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02080 State of Maryland / Department of Health and Mental Hygiene Bryon M. Travitz 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3 Time of Death Decedent's Name (First, Middle,Last) Physician/ January 27, 2012 1713 hrs Bryon Michael Travitz **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs, last birthday) If Under 1 Year 5. Social Security Number Funeral Hours Davs Months September 7,1988 Country) Virginia Director 23 227-59-3781 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No 28a-f show Columbia Howard Maryland | Pages 1 and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number U.S.A. 21045 6313 Tamar Drive 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 Married Yes 2 x No White Specify If Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed 4 Divorced <u>م</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Baltimore, MD 21215-0036 ER Scribe 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Audrey Elizabeth Sviben æ James William Travitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Columbia, Maryland 21045 6313 Tamar Drive James W. Travitz (Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 1-30-2012 Atlantic Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service 5555 Twin Knolls Road Columbia, Maryland 21045 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Medical Death Alcohol and probable drug Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tra AMENDED 23a, 27, 28a-f, per me, g925 3-1-12 sm sician/Medical X UNPENDED The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 虿 1 Yes 2 No 3 Probably 4 V Unknown ficate has been s ; page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has l performed ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other examiner? Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 Yes 2 No 1 Natural 5 Pending unknown fd 1-25-12 pm found Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State 5598 Trumps Mill Rd. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be found in graveyrad within 24 hours af To the Funeral D (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 평 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 28, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:08 20^{ay} 2012 William Reginald Teves January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 6105 Chanceford Road Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 216-01-9471 1 ፟M 2 □ F Director 93 June 3,1918 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r 10g. Citizen of What Country? Funeral USA 21228 6105 Chanceford Road Was Deceden.
Armed Forces?

Yes 2 No death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. filed within 72 hours after ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Telephone Company 6 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sophie W. Kunning George Grover Teves, Sr. 2 Department of Health and Ment; Important: If item 27 is marked any injury or cat-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Foley Quarter Road Ellicott City, MD 21042 Joan Cash (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ← Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Meadowridge Memorial Park 1/25/12 Elkridge, Maryland 21. Signa are of Funeral Service Licensee ^{22, Name and Address of Facility}
Gary L. Kaufman Funeral Home at MMP, Inc.
7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications the shock, or leart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events oidemia resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital Other: 1 🗌 Yes 0 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No Accident М Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

DHMH 17 Rev 06-2011

State

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Zelma Willoughby 2012 10:05a January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Svkesville Carrol1 Brinton Woods Nursing Center Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 74 Yrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Min. 1 - M 2 - XF Director 213-38-0456 28a-f show 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director MD Sykesville Carrol1 1 Yes 2 X No 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 230 Klee Mill Road 21784 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. or 1 þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa white Completed 3 XWidowed 4 ☐ Divorced Year or Dates Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lillie Ely Ham Shackleford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Klee Mill Rd., Sykesville, MD 21784 Cathy A. Knight (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Park Lawn Cemetery 02/01/2012 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Parai Hargent 3 Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each li d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Wed Physician/ Killas disease or condition Medical resulting in death) Due to lor as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No ŏ 5 Other (specify) Year Month Day led by the a detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s To the Hospital or Attending Physician: The law autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🖪 Natural 5 Pending work 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Wilson :50P January 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Seasons Huspice) e Northwest HOSpital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** Hours (Month, Day, Year) 243.24.9331 Director 1 **X**⋅M 2 □ F 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State death with the Maryland Director MD Baltimore Uak 1 Yes 2 No GWINN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Ferndale Avenue 3304 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married реттіт. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 ₩Widowed 4 □ Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 1 Vansportation MICK Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Dalsy Shoats Wilson 19a. Informant's Name/Relationship (Type, Print) Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) akue Bown Daks Owings Mills, MD 2117 Brookside 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 02/04/2012 Woodlawn, MD 4 Donation 5 Other (Specify) Woodlawn Canatan 21. Signature of Funeral Service Licensee Vaugn C. Greene Funeral Services 22. Name and Address Facility Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final End. Stage Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 1 ☐ Yes 2 L Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been sig funeral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours a er death. Funeral Director: After this 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho
To the Fune
completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nsligapatrem.D. D0057465 1/28/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 703 Bultmore NO N. S. Rajapakse, M.D. 2835 Smith AV Year 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G923 d1/30/2012 JH Health and Mental Hydiene

			For State Registrar	* **** Staffe of th	-	artine nt छ। । rtificate of L			ene 3. No. 2012	2 02084		
ï	Physicia	_	Decedent's Name (First, Middel CLAUDE	lie, Last)	WHEEL	ER	2. Date of Death JANUARY					
	Medic Examin	_	4a. Facility Name (if not institution			1	Location of Death		4c. County of Deat			
*	Funeral Director		5. Social Security Number 2/4-/8-/590		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bir (ear) Co	thplace (State or Foreign untry)		
		_	Usual Residence of Decedent 10a. State 10b. Count		10c. City, Town or Lo	ocation		2/15/	1923	10d. Inside City Limits		
	Marylar 28a-f s otified	irecto	MD HAK	ford	Fore		<u> </u>			1 Yes 2 No		
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	300 Kimak	11 0+	unit >	10f. Zip Code	050	10	g. Citizen of What Co	ountry?		
	r death r items iner mu		11. Marital Status 1 Never Married	12. Was Deceden	NI m	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
UU S	72 hours after n "natural", or fledical Exami	ted by	3₩Widowed 4 □ Divorce	ed If Yes, Give Year or Dates.	Specify: W	ite						
-012	e filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show ovent, the Medical Examiner must be notified at.	Completed		ent's Education hest grade completed) College (1-4 o	(Give	edent's Usual Occup kind of work done OO NOT use retired)	pation during most of work	ding 1	6b. Kind of Business.			
7170	ed within Hygiene. other thai	Be Co	17. Father's Name (First, Middle,			oner/	18. Mother's Nam	ne (First, Middle, Ma		mployed		
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Mar	12 shoulth an 27 is r trau		19a. Informant's Name/Relation	ship (Type, Print)	19b. Mail	ling Address (Street	and Number or Rui	f D For	City or Town, State, Zi	(V) 21050		
ore,	of ± to		20a. Method of Disposition 1 Burial 2 Crematio		20b. Place of Disposeretery, cre	ematory or other pla	i ./_	Date 2	0c. Location - City or			
Baltimo	permit. Page Department of Important: If any injury or once,		4 Donation 5 Other 21. Smature of Funeral Service		Dakk	22. Name and Addre	ess of Facility B	1/20121.	Balhmo Ashton	Fuveral		
n T	e a m e e		23a. Part 1. Enter the disease,	or complications that caus	ed the death. Do not en	Home, D	A , 2134 ng, such as cardiac	or respiratory arres		Rd. 21232 Approximate		
	-h, si ian/		shock, or heart failure. Lis Immediate Cause (Final disease or condition		Interval Between Onset and Death							
e de	Medical Examiner		disease or condition resulting in death) a. Cuch for as a consequence of):									
	ait d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in	b. Due to (or a	s a consequence of):			3				
	ate be executed physician and the burial-transit	Ехаг	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	c							
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s, F.O.	res that th signed by d be detac	þ	Part II. Other significant condi	tions contributing to death	n but not resulting in the	underlying cause g	iven in Part I.			o use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed	Dealiles	prior to death?	24b. Were autopsy findings available prior to completion of cause of death?							
Vital H	cian: Th ertificate ector, pa	Be	25. Was case referred to medical examiner?	Hospital:		LOH	Place of Death (Che					
n of VI	ding Physi h. After this c funeral dir	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident Inve	1 ☐ Inp 28a. Date of in (Month, I	atient 2 ER/Outpati njury 28b. Time Day, Year) injury	ent 3 L DOA 28c. Inju	y at Nursing F	tome 5 Resider 28d. Describe hov	nce 6 Other (Spe v injury occurred	cify)		
DIVISION	I or Atten after deat Director:	Certificate:	3 Suicide 6 Cou	28e. Place of	Injury - At home, farm, s etc. (Specify)				tion (Street and Number or Rural Route Number, or Town, State)			
	e Hospita 24 hours e Funeral	Medical	Chook 2 Medica	ng Physician: To the best I Examiner: On the basis on Ing Nurse Practitioner: To	f examination and/or inve	estigation, in my opin	ion, death occurred	at the time, date and	l place, and due to the	cause(s) and manner stated.		
-	To the within To the comp	-	29b. Signature and title of certif			29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)		
7)		30. Name and address of person	on who completed cause of	f death (Item 23a) (Type		2259		Anoney 2	+, 2017		
	Sta	te.	DAVID DUNN -	32. Regi	CPHAIL ROAD strar's Signature		AIR, MD.	21014				
	Registr		JAN 3 0	2012 Percha	strar's Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N		d / Depa	artment o	f Health a			ene g. No.2 ()	2	02085	
	N1-1		1. Decedent's Name (First, Middle, La							Date of Death Month	Day Y	ear	3. Time of Death	
ŀ	hysici: Medic/		Herbert Charles 1							nuary	25 201		3:12 P M	
	Examin	er	4a. Facility Name (If not institution, given 613 Wyngate Drive	re street and numbe	ər)			n, or Location (lerick	of Death			4c. County of Death Frederick		
	aral			Sex 7.	Age (In yrs.	last birthday)	If Under 1 Y	ar If Under	24 Hrs. 8.	Date of Birth (Month, Day,			ace (State or Foreign try)	
	uneral rector			1.3XM 2□F	80	Yrs.	Months Da	lys Hours	Min. Ja	nuary 2	5,1932 \	/irgi	nia	
P	> 200		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					10	Od. Inside City Limits	
lanyla	shove ad et	៦	Maryland Freder	ick	100. 011		erick						1 ☐ Yes 2X No	
the A	28a-	Director	10e. Street and Number	ICK		1100	10f. Zip Coo	de		10	g. Citizen of Wh	at Count	try?	
death with the Maryland	3a or	io	613 Wyngate Drive				217	7 01			U.S	5.A.		
deat	ems 2	Funeral	11. Marital Status	12. Was Decede		.S. 13.	Was Decedent If Yes, specify	of Hispanic Ori Cuban, Mexical	igin? (Specify	Yes or No- an, etc.)	14. Race - Black,	America White, e		
atter 50	or th	by Fu	1 Never Married 2 Married	1 XYes 2 If Yes, Give	□No		1 ☐ Yes 2 📆				Specify:	Whi	to	
Z1Z13-UU30 Id within 72 hours atter giene.	id other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Date	s:	16a. Dece	dent's Usual O	ccupation		1	6b. Kind of Busin			
C 1	n "na	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	or 54\	(Give life.	kind of work d DO NOT use re	one during mos stired)	st of working					
d with giene	other then vent, the Ma	E O	10			Drive	r				Retail S		<u> </u>	
Yland Z	d other	Be	17. Father's Name (First, Middle, Las					18. Moth			faiden Sumame)			
Mer de		၉	Herbert Charles Wol			405 14-10	4 dd (04				cey Lamb City or Town, St	ato Zin	Code	
Mar d 2 sho th and	7 Is m traum		19a. Informant's Name/Relationship Steve Wolfrey (Son				ng Address (St Long Corr				yland 2177		Code	
eal a	If item 27 Is marke or other traumatic		20a. Method of Disposition	<u> </u>	20b. F	Place of Dispr	esition (Name o	of I	Date		20c. Location - Ci		wn, State	
Pages ent of	nt: If i		txxBurial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special	☐Removal from Sta fv)	te Coc	k's Cre	matory or other ek Presby etery	terian	1-30-201	12	Hassison	nire.	Virginia	
Saltimore, permit. Pages 1 a Department of Hea	Important: If ite any injury or ot once.		21. Signature of Funeral Service Live	ensee	Molo	2	2. Name and A				1 Homes, 1			
n & 8	E % S		MAKKH	Du			5555 Twi		Road (olumbia	, MD 21045		Approximate	
/M	sician edical miner	il	23a. Part1. Enter the lase, or conshock, or heart ailure. List only disease or condition resulting in death) Sequentially list conditions.	a. Due to (or	h line.	CELL: quence of):	LUNG			spiratory are		_/	Inferval Between Onset and Death	
68 / 6U, ificate be executed	physician and s the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
.O. BOX the death cert	by the attending plotached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outco 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Feta tat time of c	il death 3	□Ectopic pregr □ Other (s <i>pecil</i>				23d. Date Monti		ery Day Year	
rdS, P	been signed t should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. ACUTE MYGLOBENDUS LEVEEM /A—								Did tobacco use contribute to the cause of death? Yes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \)			
	ite has age 2	Complet								24a. Was an autops perform 1 ☐ Yes 2	y pri ned/2 de	or to cor ath?	psy findings available mpletion of cause of	
VITA ician:	certiticate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	The Wes	3507				Check only on			300'S	
o ę	Atter this uneral di	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No							V) RESTREACE			
DIVISION el or Attending s after death.	al Director: / ad in by the f	Certification:	2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specily)									eet and Number or Rural Route Number, State)		
Lo the Hospitel	To the Funeral Directompletely filled in by	Medical		Physician: To the baminer: On the bas and manne										
To the	Tot	Σ	29b. Signature and title of certifier	9/2	1	1_\(\Delta\)	29c. L	cense number	1	2	9d. Date signed	Month,	uay, Year)	
40	yn		29b. Signature and Alle of certifier 29b. Name and address of person where the second	completed cause	of death (Ite	m 23a) (Type	Print)	NOM SO	r fr	esen	CK MI) 2	1701	
	St	ate	31. Date filed (Month, Day, Year)	32	istrar's Sign	ature		-/,	11	. / .	-			
	Regist		JAN 3 0 2	012 /21	رسا	8. Su	arlas							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Geneva Watkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 25, 2012 1639 hrs adical Examiner Geneva Knotts Watkins 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie **Baltimore Washington Medical Center** 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year Funeral Months Davs Hours Director 578-66-3707 9-26-48 Country) 1 M 2 X F 63 NC Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No MD Anne Arundel Odenton 28a-f show or items 23a or 28a-f shomust be notified at once. hours after death with the Maryland Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 692 Lions Gate Lane 21113 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12, Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 1 Yes **Black** 4 X Divorced If Yes, Give Year 1 Yes 2 A No specify: 3 Widowed Specify: "natural" è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other injury or other trees. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Food Industry Waitress 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Bertha Mae Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 692 Lions Gate Lane, Odenton MD 21113 Devona F. Phelps/niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/29/2012 Catonsville, MD Metro Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Signature of Funeral Service Licensee M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** en Onset and failure. List only one cause on each line. /Medica Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate ause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and hysician/Medical AMENDED 23a, 27, per me, $g_{925} = 3-8-12 \text{ sm}$ X UNPENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed' certificate h ector, page Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical of Vital examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 1 🗸 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1 X Natural 1 Yes 2 No Pending Director: I in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after e Funeral Direc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number January 28, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. 31. Date filed (Month, Day Registrar's Signatu State ماسيويدا

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 Мд Woiciechowski 2012 12:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Lutherville-Timonium Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Days Hours 09/22/1913 Director 219-62-6730 98 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett 1 Yes 2 X No Swanton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1384 Green Glade Road 21561 U.S.A. "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 🗌 Yes 2 💢 No 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Scelsi Marie Manzella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank I. Wojciechowski, Jr., Son 8529 Gradien Drive, Baltimore, MD 21236 JANUARY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombrent Gardens of Faith 01/30/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death AGE Physician/ DEMEN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ပု 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death, To the Funeral Director: After 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4

Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 **Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 2300 DULANEY VALLEY ROAD TIMONIUM MD JUSTINE PREIS, CRNP

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Physician/ WECKESSER UIS B 2012 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Baltimore-Washington Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) **Director** 214-38-9653 1 **⊠** M 2 □ F 69 June 3.1942 Marvland Usual Residence of Decede show 10a. State # 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Anne Arundel Glen Burnie ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 1143 Mchenry Drive U.S.A. 21061 items and 2 should be filed within 72 hours after death "natural", or iterr edical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed er than "natur , the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Tile Setter Local 01 Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ В. Louis Weckesser, Sr Mary Kindle Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Ward (Daughter) 1143 Mchenry Drive Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Pk. 01/31/2012 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ physein disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the at 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed nox 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsv performed? Yes 2 No within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in hour shoet. 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 L ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 Yes 2 No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27/2012 D14136

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DHMH 17 Rev 06-2011

State Registrar Burnie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALT/T S. SAW HN C

Glen

32. Registrar's Signature

Crain Towers

31. Date filed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Peter Curtiss Anderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 10720 Powell Rd. Sharpsburg Social Security Number If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 7/18/1943 New York **Director** 104-34-0060 1 JM 2 JF Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Washington Sharpsburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 0 Funeral 10720 Powell Rd. 21782 23a 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, ed other than "natural", or iter event, the Medical Examiner Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 25 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) car dealer manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Anderson Dorothy Curtiss 1 and 2 should be of Health and Mei item 27 is mark and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Kathy Anderson (Wife) 10720 Powell Rd., Sharpsburg, MD 21782 20b. Place of Disposition (Name of Date 3/2012 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Mountain View Cemetery cemetery, crematory or other place) Sharpsburg, Storature of uneral Servi Donald B. Thompson Funeral Home Q DY POB 18 Middletown, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only in cause on each line. ause (Final MD Enter the disease. Approximate Interval Between Imm ause (Final Onset and Death Physician/ cancer disease or condition Medical resulting in death) Due to (or as a consulence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d Date of delivery Box 1 ☐ Live Birth 2 ☐ Fetal 300 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No Po Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe performed? Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Atatural 2 Accident 3 Suicide 4 Homicide 5 Pending injury Division Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0067691 01-12-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Gregory Goldstein, MD STREAT Frederich

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Januar 20 er 0 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genera ambridge 8. Date of Birth (Month, Day, If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Hours Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 ✓ Yes 2 ☐ No 28a-f 10g, Citizen of What Country? 10e. Street and Number ö r items 23a or ner must be n Funeral Greenwood Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No ò þ 1 Yes 2 1 ☐ Yes 2 W No Specify: Specify: 3 Widowed 4 Divorced RIack Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Picker earood Industry h and Mental Hygien 7 is marked other th Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ ugh mportant: If tem 27 is marke ny injury or other traumatic orge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 rlene 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ō 1 Burial 2 Cremation 3 Removal from State Midshore Crenation 16/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Funeral Home, P. A. Henry. StiCaM ington 23a. Perd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Edienic Cardion Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Section fields list out office a Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sea Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 1 ☐ Yes 2 ☐ No this certificate Yes 2 L Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? Natural Accident 5 Pending death. Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D0068045 07 2012

Registrar

State

CAMBRIDGE

MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BYRN

JAN 12

31. Date filed (Month, Day, Year)

STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0tis Avant, Sr. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death County of Death Examiner Prince George Regional Hospita Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours May 9,1928 Mississippi 356-20-4149 83 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 28a-f 1X Yes 2 ☐ No Laure1 Maryland Prince Georges 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō Funeral 23a United States 11407 20708 Laurel Walk Drive items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian. rmed Forces?
X Yes 2 \(\square\$ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give **Black** 3 Widowed 4 N Divorced "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Avant's Auto Clinic 12th grade Owner & Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucille Golladay Prince Avant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i 9801 Franklin Avenue; Seabrook, Maryland 20706 Adrian Avery Avant, Sr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State Cheltenham, 20a. Method of Disposition Department of H Important: If ite any injury or oth Page 1 Jan. 23° , 2012 1 X Burial 2 Cremation 3 Removal from State Maryland Cheltenham Veterans Cemetery 4 Donation 5 Other (Specify) Maryland 21. Sonature o Funeral Service Lipenses Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
5 YELLS shock, or heart failure. List only one cause on each line Immediate Cause (Final Congestive Heart Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ardiomyopath ears Sequentially list conditions, if any, reason to immediate cause. Enter Underlying Cause (Disease or iinjury Examine teriosclerotic burial-transi Heart and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death signed by the all d be detached for Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown should should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a, Was an page 2 autopsy performed? Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 **X**No 1 Inpatient 2 XER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

UR 2

State Registrar 30. Name and address of person who completed cause

22966

eath (Item 23a) (Type, Print) 7300 Van Dusen Road

aurel Regional Hospital

2012

MD

20707

aurel.

Emergency Dept

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State	of Marylan	-	irtment of F tificate of L		Mental Hygi				
			Registrar 1. Decedent's Name (First, Middle, Last)		007	incate of E	Journ .	2. Date of Death		3. Time of Death		
н	Physicia Medic		John Raymond	3			Janaury 2					
and the same	Examin		4a. Facility Name (if not institution, give street and r	Location of Deat . Washi		4c. County of Dea	th George's					
- myret	Funeral		Fort Washington Rehabil 5. Social Security Number 6. Sex.	7 Age (In vrs. la		If Under 1 Year	If Under 24 Hrs	8. Date of Birth	g. Bir	thplace (State or Foreign		
	Director		220-16-8852	F 84	Yrs.	Months Days	Hours Min.	May 19,	1927 N	Maryland		
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limits		
	Aaryla 8a-f s tiffied	Director	Maryland Prince George'	s			Oxon H	i11		1 🏿 Yes 2 □ No		
	a or 2 be no	ا ق	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co			
	th with ms 23 must must	Funeral	7300 Dominion Drive	ecedent Ever in U.S	112.1	207		pecify Ves or No-	United St			
21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	þ	Armed	Forces? es 2 🗌 No Give		Vas Decedent of H Yes, specify Cuba		to Rican, etc.)	Black, Whit	te, etc. rican		
15-0	2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade complet	red)	(Give I	ent's Usual Occup aind of work done	ation during most of wo	rking	16b. Kind of Business	Industry		
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pd 2	filed wall Hygi I other vent, i	Be	17. Father's Name (First, Middle, Last)		· · · · ·			me (First, Middle, M	aiden Surname)			
ylaı	should be file and Mental I is marked c raumatic eve	ျ	James Aaron Ar	mstrong				Ada Matil				
	of Health and Mente of Health and Mente of item 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print) Evelyn M. Armstrong -	Wife		g Address (Street Dominion			City or Town, State, Zi L, Marylan			
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State	emetery, cren	sition (Name of natory or other place ington Cemet	ं चता	uary 26,	20c. Location - City o	r Town, State		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensed	ant, = 5	> 22	. Name and Addre	ss of Facility St		neral Home			
			23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause or Immediate Cause (Final	each line.				c or respiratory arres	st,	Approximate Interval Between Onset and Death		
1000	Medical			1i nant R to (or as a consequ		rioreal S	arcoma					
	Examiner	ē	Sequentially list conditions, Due to jor as a conscruence of									
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	cate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):									
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	ertifica ding pl		IF FEMALE: 23c. If yes.	outcome of pregna	ncv				23d. Date of de	olivany		
. Box 68	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transi	Physician/M	in the past 12 months?	ive Birth 2 Feta regnant at time of c Inknown	al death 3	Ectopic pregnand Other (specify)	ру 		Month	Day Year		
ls, P.O.	v requires that to been signed be should be deta	by	Part II. Other significant conditions contributing t	o death but not res	ulting in the u	nderlying cause gi	ven in Part I.	cco use contribute to the cause of death?				
Division of Vital Records,	sician: The law requires that the certificate has been signed by the rector, page 2 should be detach	Completed						24a. Was ar autops perforn 1 Yes 2	v prior to	utopsy findings available completion of cause of es 2 \(\square\) No		
tal	cian: ertifica ector,	Be	25. Was case referred to medical examiner?			26. P	lace of Death (Ch					
Ϋ́	Physician: this certific ral director,	2	1 ∐ Yes 2 LXNo	Inpatient 2 ate of injury	ER/Outpatier 28b. Time of	it 3 🗆 DOA	4 124 Nursing	Home 5 Reside	nce 6 Other (Spe	ecify)		
o uc	nding ath. :: After e fune	icate	1 Natural 5 □ Pending (Natural 2 □ Accident Investigation	Month, Day, Year)	injury	wor						
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pl bu	reet and Number or R State)	eet and Number or Rural Route Number, State)							
	e Hospi 24 hou e Funera eleted filla	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the only ane) 3 Certifying Nurse Praction	basis of examination	n and/or inves	tigation, in my opini	on, death occurred	d at the time, date and	d place, and due to the	e cause(s) and manner stated.		
	To the within 2 To the comple	2	29b. Signature and title of Certifier			29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)		
)			M			-245	フン	01,12,	, 2012		
D			30. Name and address of person who completed of Laxmi N. Berwa 7700 B	cause of death (Item			Clinto	on, Md. 2	20735			
	Sta	te		2. Registrar's Signat								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kanks 10:40 AM ugene 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ta HOSP IK ton 0 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 DF Months Days (Month, Day, Year) Mary land 213-44-935 6 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Director MD ELKTON eci 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CourT Funeral Southland 2 1921 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No
If Yes, Give 3 3 1 6 7
Year or Dates. 8 - 30 - 70 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Herospace eader rew Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ anks race 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southland Court, ElkTon, MD eborah Banks 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Bear, Memil Cemetery 23/12 4 ☐ Donation 5 ☐ Other (Specify) Vet FUNERAL Signature Funeral Service 22. Name and Address of Facility CONGO 201 N Gray Ave POBOX 2593, Wilm DE 19805 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death a I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes Hospita Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident
Suicide Investigation 24 hours after deal Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b/Signature of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

4 +IVA

State

NID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Physician/ January 12. 2012 Costella Onithia Godfrey Bynum 1531 Hrs^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince Georges Southern Maryland Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 943 Director 242-64-7026 68 1 M 2 X F September 14, North Carolina show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 X Yes 2 No Maryland Prince Georges Fort Washington 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1908 Valley View Drive 20744 United States or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Armed Forces?
1 Yes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after Yes Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than " **Knight Security** Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other trainment. Security Guard Company 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Benjamin McGill Godfrey Essie 19a. Informant's Name/Relationship (Type, Print)

Douglas Bynum (Husband) & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanier Avenue; Suitland, Maryland 20746 Derrick Lamont Bynum (Son) 5511 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cometery, crematory or other place) Jan. 21, 2012 4 Donation 5 Other perify National Harmony Memorial Park Landover, Maryland ignatur of uneral Se 2. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ al disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burial physician s the burial Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 mopths?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death ed by the a Unknown 9 Unknown P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed 1 Yes 2 No Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 2 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury Director: After t d in by the funera 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after thin 24 hours a the Funeral Dompletely filled Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2012 Physician/ 10:00A^M 13 01 Barry Jesse Barrentine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Smith Road 7. Age (In yrs. last birthday) 1 Year Days If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours (Month, Day, Year) 05/08/1939 Country) **Director** 163-32-6006 Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Cecil Elkton 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21921 USA 2 Smith Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Business Private Investigator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Rita A. Lucas William J. Barrentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau once. Helena Barrentine - wife Smith Road, Elkton, MD 21921 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lower Brandywine Cem. 01/19/2012 Wilmington, DE 21. Signate of Funeral Service Litensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph lician/ CONGESTIVE Heat Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chrone obstructor pulminary Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (ones a consequence of) and I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ¥ Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed Chronic amenica from gastrointestral 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 🗵 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 29b. Signature and title of certifier 29c. License number MARYLAND 29d. Date signed (Month, Day, Year) Junes R. aleaunt Ms 0000 3740 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w. Main St. Newark, Dec. 19711 n Deruoity 32. Registrar's Signature 167 31. Date filed (Month, Day, State JAN 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pancita Salome Brydson 2012 12:41 P.M January 8. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner HOLY Cross Hospital** Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year)1958 West 220-15-9357 Director 1 🗆 M 2 🗶 F 53 October 11, Jamaica, Indies Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f sh must be notified a 1 X Yes 2 □ No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10009 Gable Manor Court 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married ò þ 2 **X** No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene, the 2 years Operator/Proprietress Ice Cream Store marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Icilda Haye George Brydson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20011 1401 Sheridan Street, N.W.; Apt. 207; Washington, D.C. Harry Brockenberry (Husband) other Important; If iten any injury or othe once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan.21,2012 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 andan. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, burial-trar Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 **X** No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pneumonia Records, 1 Yes 2 No 3 Probably 4 Number Cardiomyopathy Heart Failure 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2**X** No prior to completion of cause of death? has 2 No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 **X** No ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the

State

Registrar
DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

JAN 1

7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Chuanbo Zhang, M.D.; Holy Cross Hospital; 1500 Forest Glen Road; Silver Spring, Maryland

D65915

29d. Date signed (Month, Day, Year)

January 8, 2012

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **K** M 2 \square F Months Days Hours Country) NC Director 67 077-39-5306 Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20853 AZU 4704 Iris St. er than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working if Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 15 Sales Distributor Coca-Cola other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lurenda Ellen Page 1 and 2 should be Hiawatha Berry Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 18315 Honeylocust Cir., Gaithersburg, MD 20879 <u>Christina Berry / daughter</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Strickland Cemetery Department of Important: If it any injury or o 🕱 Burial 2 🗆 Cremation 3 🗔 Removal from State Mount Airy, NC 07/73/5075 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Strickland Funeral Services 21. Signatur Funeral Service 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final - Physician/ ritherosc protic disease or condition resulting in death) y ears Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant
9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one)

State Registrar

DHMH 17 Rev 7/2009

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montgomery beneficial

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 8 per FH G924 2/3/12 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2012 Jan. 1:00 P M Theresa Marie Blute 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Caroline Envoy of Denton Denton If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 🔀 New York City 141-09-5272 94 11, 1917 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 No Caroline Henderson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21640 USA 26281 Bee Tree Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress and Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adam Eckstadt Teresa Ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bob Jarrell/Executor P. O. Box 600 Denton, MD 21629 20a. Method of Disposition
1 → Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State Greensboro, MD Greensboro Cemetery 1-19-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 106 W. Sunset Ave. Box 160 21. Signature of Funeral Service License ly Fleegle and Helfenbein Funeral Home Greensboro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION MINUTES Due to (or as a consequence of): CARDIOVASCULAR DIKEASE ATHIRO SCLEROTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA, ISCHEMIL CARDIOMYOPATHY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION, RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1□ Yes 2 No ber.

that the death certificate be executed and burial-tra physician the as for use the detached þ Hospital or Attending Physician: The law requires director, page 2 should certificate has this funeral After t

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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death

1 and 2 should be filed within 72 hours after the thealth and Mental Hygiene.

altimore, Maryland 21215-0036

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'natural'; or items 23a or dical Examiner must be

traumatic event, the Medical

Department of Health an Important: If item 27 is any injury or other trateonce.

Physician

/Medical

Examiner

Pages 1

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

MD

20.	. was case refer	eu to medicai	26. Place of Death (Check only one)									
	examiner?	No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 D0	OA Other: 4	Nursing Ho	me 5 Residence	6 □Other (Specify)			
27.	Manner of Death 1 Natural 2 Accident	n 5 □ Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2		28d. Describe how inju	ury occurred			
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		At home, farm, stree Specify)	t, factor	y, office		28f. Location (Street a City or Town, Star	and Number or Rural Route N te)	иm		
29	a Certifier	138 Certifying Ph	hysician: To the best of m	v knowledge, death o	ccurrec	at the time, date	e and place.	and due to the cause((s) and manner as stated.			

The destination in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi

AUE HEDERALSBURG, MD21632 321 BLOOMING BALE

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 8 2012

32. Registrar's Signature

within 24 hours after death.

To the Funeral Director: A filled in by the

the

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 01 2012 10Donald Balderston 10:48 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 1865 Liberty Grove Road Colora Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 🖾 M 2 🗆 ₽ Min. Hours (Month, Day, Yea 5/13/192 Director 88 220-07-3339 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Cecil Colora 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1865 Liberty Grove Road 21917 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married 1 Yes 2 XNO Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed White Year or Dates id Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Farmer Orchard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Levi Balderston Anna Runner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Balderston - wife 1865 Liberty Grove Road, Colora, MD 21917 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, PA Rising Sun, MD 21. Si ure o Funeral Service Licensee 22. Name and Address of Facility RT Foard Funeral Home, PA S. Queen Street, Rising Sun, MD 21911 111 23a. Part 1 shock . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one ca COYMON Immediate Cause (Final Physician/ disease condition resulting n death) Medical Due to (or as a o Examiner DW msion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cons - uence of) that initiated events resulting in death) Last that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate 1 🗌 Yes 1 Yes 2 No 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27 Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Division of Vital Records, Hospital or Attending Physician: The law requires

10

Registrar DHMH 17 Rev 7/2009

State

Medical

1 Natural

3 Suicide 4 Homicide

29a Certifier

(Check only one)

Accident Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending

Investigation

Could not be

91h

JAN 13

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WN15

32. Registrar's Signature

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d. Date sighed (Month, Day, Year)

13

1 2-

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Benitez 845 PM orase 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Northwest Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 215-23-8895 1 X M 2 □ F 56 02/15/1955 El Salvador Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified Maryland Prince Georges Hyattsville 1X Yes 2 🗌 No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 20783 El Salvador 2114 Saranac St. ıral", or items ? | Examiner mus 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. , o. þ 1 Never Married 2X Married 1 Yes 2 **X** No Baltimore, Maryland 21215-0036 1

▼ Yes 2 No Specify: Salvadorian Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Calvert Masonary Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luisa Benitez မ Facundo Benitez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2114 Saranac St. Hyattsville, MD 20783 Health tem 27 other <u>Maria Granados-Wife</u> 20c. Location - City or Town, State Corinto, El Salvador 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 cemetery, crematory or other place) Department of Important: If any injury or once. Cementerio Municipal 01/22/2012 21. Signature of heral Service Licensee Rendon/Hale Funeral Home 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, MD 20706 23a. Pard. Enter the disease, or cemplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician/ Lec 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or). attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, amponade 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 Mother (Specify) 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🔲 No s after death. I Director: After t 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury r death. 2 Accident filled in by the Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certific Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Ched To the I within 2 only one 3 [29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 005333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 12-00531 Larry Burgess Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arry Burgess		- For State	ate of Mar	yland / Dep Ce	artment o e <i>rtificate</i> o			d Menta	l Hygiene	Reg. No	. 201	2	0210)	
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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Und	hs Day	\rightarrow	Min	•		eign			
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Division of Vital To the Hopital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Exa	aminer:On the ba	asis of examination	and/or investi	gation, in n	ny opinio	n, death occu	irred at the time, d	ate and	place, and due t	o the	cause(s)		
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	-	30. Name and address of persor	who completed	cause of death (It	em 23a)									-	
CK		Melissa Brassell, MD		Medical Exan		W. Balti	imore S	Street, Ba	timore, MD 2	1223					
Sta	te.	31. Date filed (Month, Day, Year)		2. Registrar's Sign	ature									_	
Registra	-	JAN 2 5 2012	A	A S	hared										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Binkley 1313 1 Joe JAN 10 2012 Medical 4a. Facility Name (if not institution, give street and numbe **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAL156414 HICOMICO REGIONAL Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 **Funeral** Days Months Hours **Director** 300-38-1008 1 **X** M 2 □ F 64 04/21/1947 Ohio show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral death with 31784 Kenilworth Drive 21804 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 X Married be filed within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Advertising Sales Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lyle Binkley Beulah Irene Hall and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Anne M. Binkley/Spouse 31784 Kenilworth Dr., Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/13/2012 Salisbury, MD 21. Signature of Funeral Service Licen-Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Phytician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physiclan Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown signed by the ar 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen Were autopsy findings available prior to completion of cause of Was an has page 2 autopsy death? certificate 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No ρ 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral (27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after ueaun.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number 01/12 0066986 1010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mirza md. 2188 1000 arroll St. Salish Registrar's Signat 2 2012 Backs

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHAMO BELL W. DANUARY 3:30 pm Medical 2013 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL GLEN BURNIE CENTER ARUNDE 3MME **Funeral** 8 Date of Rirth Birthplace (State or Foreign Country) (Month, Day, 1 ▼M 2 □ F Hours Director 28a-f show 10a. State the Maryland must be notified at **Funeral Director** 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 23a or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2164 , or items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or ite Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. Specify: WHITE Completed 3 Widowed 4 Divorced ed other than "natu 16a. Decedent's Usual Occupation
(Give kind of work done during most life. DO NOT use retired)

MECHANIC 16b. Kind of Business Industry (Specify only highest grade completed) (Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental F 27 is marked of traumatic ever ٩ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or t of Health a ROAD HURLOCK 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State = 5 1 Burial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) Signature of Puneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician disease or condition resulting in death) **ARDIDGENIC** ONE HOUR Medical **Examiner** LI DOSIS TWO HOURS Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner HYPOVOLEMIA cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last TWO HOURS CORGULOPATHY WITH BLOOD LOSS P.O. Box 68760 LMO HOURS IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

Funeral Director: After this certificate has performed? Yes 2 No 1 ☐ Yes 2 🗷 No To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 🂢 No Be 26. Place of Death (Check only one) Hospita Other: ٥ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident M 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2

To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 3B144C JANUARY 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLENBURNIE, MARYLAND 21061 R.FLINN, M.D. HOSPITAL DRIVE 32. Registrar's Signature State JAN 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Emma Marie Bowens 01 0656 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TALBOT MEMORIAL HOSPIML @ EASTON EASTON If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Hours Director 171-22-6385 1 🗆 M 2 💢 F 84 July 20, 1927 Maryland 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Hurlock Dorchester MD 1 🗌 Yes 2 🎗 No 0 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 21643 4463 Preston Road United States items should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Force Black, White, etc 0. 1 Never Married 2 Married by Yes 2 XNo 21215-0036 Black 1 Yes 2 X No Specify. If Yes, Give "natural", Completed 3 ▼ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Dorchester Co. Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Educator of Education other Bd. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked (Cornelius Henry McGrath Emma Flossie Helena Lee Health and Important: If item 27 is m any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21601 104 Third Haven Heights, PO Box 632, Easton, MD Page 1 and 2 Edison A. Bowens/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date permit. Page 1 and Department of H East New Mkt., MD 01/18/12 East New Mkt. Cem. ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) COROMARY Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence f) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? 1 Yes 2 No death? Hyperdension 2 🗌 No funeral director, 25. Was case re erred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 \square Residence 6 \square Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred after death.

Director: After Natural 5 Pending М 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier aus 1 9004

Registrar

State

DHMH 17 Rev 06-2011

OWENS.

UTCHMANS

EASTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G/O UUT
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Garland V. Bradsher January 8, 1325 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days April 18, 1932 North Carolina 79 **Director** 243-40-9385 Usual Residence of Decedent or 28a-f show notified at 10b. County .10c. City, Town or Location 10d. Inside City Limits Director Bladensburg 1 X Yes 2 No Maryland | Prince George's 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 4202 58th Avenue # 217 20710 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 🔀 Married ò Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🖾 No Specify. Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked 2 Theadore R. Bradsher Matilda Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 58th Avenue # 217 Bladensburg, Md. Lottie M. Bradsher - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 16, 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State permit. Page Department o Important: If any injury or ò 4 Donation 5 Other (Specify) Lee's Crematory 2012 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. tolar 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ACUTE MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY ARTERY Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETTS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔊 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 \square Pending 1 Yes 2 No Investigation 6 Could not be Accident filled in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D40324 JANUARY 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRY JODRIE, MD, FACEP 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND

DHMH 17 Rev 7/2009

State Registrar 32. Registar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J^{Month}January Day 22, 2012 **Physician** 11:00 A.M Gordon Arthur Bartels /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X** M 2□ F 69 Director 075-30-9656 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or fleme 23s or 28s-f ehor Washington 1 √Yes 2 No Maryland Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 139 South Mulberry Street 21740 death U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 ie marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No 1 Yes 2 Xio Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Teacher or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Arthur Albert Bartels Helen Frances Vollbrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 South Mulberry Street, Hagerstown, Md. 21740 Janet E. Bartels Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State Hagerstown Crematory 01-23-12 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee Andrework Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Concrate Cavanoma weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2,5 No 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Tyes 2 No 2 Accident after death 6 Could not be determined 3 Suicide To the Hospital or Atta within 24 hours after de To the Funerei Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JAN 3 0 2012

Monrey

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30. Name and address of person who completed cause of death (I/em 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 1/2001

State

29c. License number

368 mell

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence Evelyn Bartgis Month 2012 10:50 A M January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick **Examiner** 4b. City, Town, or Location of Death Frederick Golden Living Center Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) 214-10-4754 98 1 □ M 2 🖔 F **Director** 1913 July 14, Maryland Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 9312 Oak Spring Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) ^{18.} Mother's Name *(First, Middle, Maiden Surname)* Mabel Floyd Carpenter Charles Ray Etzler permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Villarreal (Niece) 9312 Oak Spring Ct., Frederick, MD 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/25/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cem. 21. Signature of Funeral Service Licenses Keeney and Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death BREAST Ph_sician/ METAS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to force a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No certificate 1 Yes completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death. To the Funeral Director: A Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29b. Signature and title of ce 29d. Date signed (Month, Day, Year) DO061410 January 23, 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE, FREDERICK,

Registrar

3 0 2012

80 32. Registrar's Signature

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 101 21-2012 8:50 A M **Physician** Britton Hi lda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Easton William Hill Manor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 5. Social Security Number **Funeral** Months Days Hours 03-17-1912 1 □ M 2 F Md. 212-10-9495 99 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is to diest Evanings or ust be notified at 1 Yes 2 □ No Easton Talbot Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21601 501 Dutchmans Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 XNo à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Item 19 Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing -Õ-Buver 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sanders Arabelle Leight Harry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9220 PennyWhislte, Dr. McDaniel, Md. 21647 Patricia Bond / Niece 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crem. of Delmarva Date 01 - 24 - 2012Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hur Tevad & do Ost Fowski Funeral Home P.A. C.F.S.P. OstRowski P.O. Box 518 St. Michaels, Md. 21663 Joseph M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TAGE YEAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE ise i 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy for Month Day Year 5 Other (specify) ned by the a P.O. 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 ISCHEMIC CARDIOMYDPATHY, CHEONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? INSUFFICIENCY, ATRIAL PIBRILLATION 24a. Was an has autopsy performed? Yes 2 100 certificate 1 ☐ Yes 2 D No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated

State Registrar

29b. Signature and title of cer

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29d. Date signed (Month, Day, Year)

2012 Legible.

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	Dhi.i.i		1. Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Sarah Hannah							anuary	y 14,201	2 9:50 PM
1	Examin	er	4a. Facility Name (If not institution, give st Golden Living C					4b. City, Town, or Location of Death Hagerstown			4c. County of Dea	
	Funeval		5. Social Security Number 6. Sex		e (In yrs. la	st birthday)	If Under 1 Ye	ar If Und		Date of Birth		rthplace (State or Foreign
Pirector S. Social Security Number 1. Age (iii yis. last billionary) 2 2 4 - 5 2 - 0 7 0 7 Usuel Residence of Decedent							Months Da	ys Houi	rs Min. 9	Date of Birth (Month, Day, / 20 / 1	926 V i	rginia
	yland	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
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	한 15 6 28 18 18 18	Dire	10e. Street and Number		_		10f. Zip Cod				g. Citizen of What C	•
	s 23s	Frai	309 E. 4th Avenu		9	112.1	2543		Origin? (Specif		ited St	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28e-f ehow eny Injury or other traumatic event, the Medical Examiner must be nutified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 Yes 2 Min If Yes, Give Year or Dates:			f Yes, specify C		Origin? (Specifican, Puerto Ric	an, etc.)	Black, Wh	
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade			16a. Deced (Give	dent's Usual Oc kind of work do	cupation ne during n	nost of working	1	6b. Kind of Busines	s/Industry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	llege (1-4or 5+)		mestic			c	elf Emp	loved
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Maryland	uld be Menta rrked ric ev	To B	Frank Pendletor	1				Sa	rah Re	dlock		
lan	2 sho and I is ma		19a. Informant's Name/Relationship (Typ								City or Town, State,	
	1 and Health Im 27		William Bray 20a. Method of Disposition	Son	20h Pis				. Apt.		nson, WV	
Baltimore,	Pages ment of thant: If its lury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		rview		tery	1/20/2	2012 C	harles	
Ball	Depart Import eny In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Chapel Funeral PO Box 838, Charles Town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								al Home	5/1/
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death.	. Do not ent	er the mode of	dying, such	as cardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) Due (Labor as a consequence of):								11 Y-lorrs.		
ı	Examiner	_	Sequentially list conditions, b.									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
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O. Box	The law requires that the death cert sie hes been signed by the attendin bege 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[Ectopic pregna Other (specif)				23d. Date of d Month	elivery Day Year
, P.O	that ti		Part II. Other significant conditions conf	ributing to death b	ut not resul	Iting in the u	nderlying cause	given in Pa	art I,	23e. Did tob	acco use contribute	to the cause of death?
rds	quires an sign uld be	ed by								1 □ Ye	s 2 □ No 3 □ I	Probably 40 Unknown
Division of Vital Records,	sician: The law re certificete hes bee irector, pege 2 sho	Completed								24a. Was ar autopsy perform	y prior to ned?, death?	autopsy findings available completion of cause of
ital		0	25. Was case referred to medical					26. P	lace of Death (6	1		es Q No
\	> W TO	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 🔲 Inpatie	ent 2 🗆 E	ER/Outpatier	nt 3□ DOA	Other: 1	Nursing Home	5 ☐ Reside	nce 6 □Other (Sp	pecify)
0 0	ing Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury		njury at Work?		d. Describe ho	w injury occurred	
isio	death death stor: / the f	cat	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Ini	un - At hor	me farm st		1 ☐ Yes 2		f Location (Str	reet and Number or	Rural Route Number
Ο̈́	al or A s after d Direct	Certification	4 Homicide determined	building, et	c. (Specify))	eer, racidly, on	et, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Ph. within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best er: On the basis o and manner st	f examinati	vledge, deat ion and/or in	h occurred at th vestigation, in r	e time, date ny opinion,	e and place, and death occurred	d due to the ca at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
29b. Signature and title of certifier								ense numb			9d. Date signed (Mo	
Design that							5		1-15-	12		
	18m		30. Name and address of person who cor	hipleted cause of o	eath (Item	23а) (Туре,	Print) 8 We	ul	stud	- Hel	John	21742
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2012	32. Registr	ar's Signat							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 4 2012 2012 Physician/ 5:28 Carroll A_{M} Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Funera! Days Hours Month: 72 216-60-6153 Director 1 M 2 K F Maryland 2/13/1939 Usual Residence of Decedent 28a-f shov 10d Inside City Limits 10a. State 10c. City, Town or Location Director must be notified Maryland Edgewater 1 Yes 2X No Anne Arundel ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21037 23a Funeral 1569 Stuart Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11 Marital Status Examiner Black, White, etc. "natural", or ò 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify. Specify 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life, DO NOT use retired) than, Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ပ Eva McKenzie Robert Estep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Dove - Daughter 1569 Stuart Rd, Edgewater, MD 21037 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 1/9/2012 MD Veterans Cemetery Crownsville, MD Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License Myeli 147 Duke of Gloucester St, Annapolis, MD 21401 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Spiratiun disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed No has page 2 death? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No မြ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: neral Director: After if filled in by the funer (Month, Day, Year) 1 Natural injury 5 Pending M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c. License number JAn. 6, 2012 10% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) America Medical

State

Registrar

JAN 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death _Month Physician/ 6:50 A George Alvin Chaney annen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) **Funeral** Days 1**X** X M 2 □ F Months Hours Mir 1 Mr51/1929 82 MD 213-22-0686 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Examiner must be notified 1 Yes 2XXNo MD Anne Arundel Odenton b 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a **IISA** 21113 540 Stoney Hill CT. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 Norea If Yes, Give Year or Dates. 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Completed 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Operator 0 Bar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Frank Chaney Eva Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Odenton Road Odenton, MD 21113 Brenda Riley Neice 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial XX Cremation 3 Removal from State 01/08/2012 4 ☐ Donation 5 ☐ Other (Specify) Crematory Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Licensee Ridgely Ave. Annapolis, MD 21401 12 23a. Part 1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events Exam The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page certificate 1 Yes 2 No Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) eral Director: After this certific filled in by the funeral director, Be 2 No Other: 1 npatient 2 -1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Whatural 2 Accident 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending work 1 Yes 2 No after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated. within 24 hours a Medical 29a. Certifier Deted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a - MD. 210

State

Registrar

JAN 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kenneth Joseph Carr Jan<u>uary</u> 10 2012 1:06A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 3365 Riva Road Davidsonville Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 219-12-3788 Director 1 **X** M 2 □ F 88 9/3/1923 Maryland ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3365 Riva Road 21035 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Completed Year or Dates. W.W. II White 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Quality Control Service U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph F. Carr Mabel Aisquith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3365 Riva Road, Davidsonville, MD 21035 Florence G. Carr/ Wife 20a. Method of Disposition
1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite ö injury 4 Donation 5 Other (Specify) Kalas Crematory 1/11/12 Edgewater, MD 21. Signature Straine Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. j Approximate Interval Between Immediate Cause (Final Onset and Death MORS Physician/ 01 disease or condition Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be 68760 IE EEMALE fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Nursing Home 5 \(\frac{\text{X}}{2}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 1 Tes 2 😿 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) POS202 10% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gence Highway Swite 200 Annapolis, MCL 21401 1221 MARIA E. ROMERO M.D

Registrar

State

32 Registrar's Signature

DHMH 17 Rev 06-2011

Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

ľ	- For	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2012	0211				
ian ical iner	1. Decedent's Name (First, Middle, Last) Elena (VZ - OytiZ 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month Day Year Janory 4b. City, Town, or Location of Death 4c. County of Death					
	Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 582-78-5719 1 □ M 2 ☒ F 99 Yrs.	Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Co. Months Days Hours Min. 6 0 1 1 9 1 2 Pu =	thplace (State or Foreig untry) erto Rico				
Director	Usual Residence of Decedent	ocation Spring 10f. Zip-Code 10g. Citizen of What Co	10d. Inside City Limit 1 ☐ Yes 2 1 N				
Funeral Di	10400 Haywood Drive	20902 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame Black, White	erican Indian,				
by	1 Never Married 2 Married 1 Nes 2 No If Yes, Give Yes or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Give	1 Mayes 2 No Specify: Puerto Rican Specify: Wedent's Usual Occupation Be kind of work done during most of working 16b. Kind of Business.	hite				
Be Completed	17. Father's Name (First, Middle, Last)	DO NOT use retired) Hidmemaker Own Hotel Street St	me 				
면 I	Serafin Cruz 19a. Informant's Name/Relationship (Type. Print) Maria E. Nazario/daughter 104	ling Address (Street and Number or Rural Route Number, City or Town, State, 100 Haywood Drive Silver Sprin	zip Code) g , MG 2090				
	4 Donation 5 Other (Specify) Munici	pal Cemetery Fuerto					
		HTTTP AD RINALDI FUNERAL SERVIC 241 Columbia Blvd.Silver Sprin					
dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, beauty to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	eart failure	2 hours				
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy 23d. Date of de Month	elivery Day Year				
by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to 23e. Did tobacco use contribute to 23e. Did tobacco use contribute to 23e. Did tobacco use contribute to 23e.					
Completed		autopsy prior to performed? death?	utopsy findings availa completion of cause s 2 \(\sum \text{No} \)				
Certification: To Be	25. Was case referred to medical examiner? 1						
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and due to the cause(s) and manner a investigation, in my opinion, death occurred at the time, date and place, and d	as stated. ue to the cause(s)				
dical	and mariner stated.						
Medical	29b. Signature and title of certifier August Seums ; MD	29c. License number 29d. Date signed (Mon	ith, Day, Year)				

DHMH 17 Rev 1/2001 11595

12-00009 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nicholas Scott Clayton State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 0302 hrs Medical Examiner NICHOLAS SCOTT CLAYTON January 1, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Jones Bridge Rd and Lancaster Dr If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Davs Hours Director Country) [V]D 05/14/1991 1X M 2 F 212-33-9162 20 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items 23s or 28s-f shou ary or other traumatic event, the Medical Examiner must be notified at once. 28a-f show Rockville Montgomery Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 20851 12939 Twinbrook Parkway Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No 3 Widowed If Yes, Give Yeer 1 Yes 2 X No specify: Specify: White 4 Divorced or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Concession Worker Fedex Field 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Kathleen M. Atchison Be Kenneth Scott Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12939 Twinbrook Parkway, Rockville, MD 20851 Kenneth S. Clayton/father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 01/13/2012 Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last has been signed by the attending physician and the should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, Boxpital or Attending Physician: The law requires that the death certificate be executed hysician/Medical UNPENDED **AMENDED** IE EEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 黿 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes this certificate ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? -lospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Passenger in motor vehicle collision Certification ___ Natural FOUND: 1 Yes 2 V No 5 Pending Jan 1, 2012 0302 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Jones Bndge Rd and Lancaster Dr, Bethesda, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. January 1, 2012 Oel 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month. Registrar's Signa State TT 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 6:00 A M JAN. MIRALDO PONCE CAMPBELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SAINT THOMAS MORE NURSING HOME HYATTSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. JUNE 29 1**X** M 2 □ F Months Days Hours HONDURAS Director 80 137-98-2212 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I hat it item 27 is marked other than "natural", or items 23a or 28a-f show or items 23a or 28a-f shomininer must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No PRINCE GEORGE'S HYATTSVILLE MD. 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20783 U.S.A. 8106 14th AVE. APT. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14 Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ASIAN INDIAN Completed 3 - Widowed 4 - Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHIPPING **ENGINEER** 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **PONCE** LOLITA CAMPBELL LEONCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14th AVE., APT. 2, HYATTSVILLE, MD. 20783 MAHARAINA PONCE CAMPBELL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-14-2012 RIVERDALE, MD. Signature of Funeral Service Lie See CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 207 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ANTEMUSICERONZ CARDIOVABLULAR DISCASE Immediate Cause (Final Physician/ y ears disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine e attending physician and and for use as the burial-transit Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory Failure I ventilator Dependent 1 Yes 2 No 3 Probably 4 Unknown ATMAR Fibrillation End Hage Renal Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Itemodialysis | Yes 2 XNo sacral decubitis Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REMD 42036 VEENSbung 12d Hyattsv. 11e MD 20781

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

12-00087	_		Print in Black Inc				ible.	
Charles Thomas		mper State of	Maryland / Depar	tment of He ificate of De			201	2 0211
Dhysisis		Registrar 1. Decedent's Name (First, Middle,Last)	Cen	ilicate of De	alli	Reg 2. Date of Death	. No.	3. Time of Death
Physicia Medical Exami		Charles T	hamas (amper			Day Year 2012	1549 hrs
		4a. Facility Name (if not institution, give st 9401 New Road	reet and number)	4b. C	ty, Town, or Location of De , Michaels		4c. County of Death Talbot	
Funeral Director		5. Social Security Number 6. Sex 15-44-6960 1 M	7. Age (In yrs. las		Under 1 Year If Under 24 onths Days Hours M	Hrs. 8. Date of Birth Min. Sept. 17,	(MM/DD/YYYY) 9. 8irt 1945 Con	hplace (State or n Mary land
\$ 1		Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Location	**			10d. Inside City Limits
1 B		MO talbot		Easto	10			1 Yes 2 No
farylar at on	ecto	10e. Street and Number			Zip Code	100	. Citizen of What Cour	ntry?
MOre, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	211 Wye 1	Avenue		21601		USA	
th with	era		2. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin? (pecify Cuban, Mexican, Pue		14. Race - Ameri White, etc.	can Indian, Black,
er deat	Ξ		Yes 2 No		2 No specify:		Specify: Blo	N
irs aft.	Ď	15. Decedent's Education (Specify only	Dates:		ual Occupation (Give kind	of work done	6b. Kind of Business/I	
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	working life, DO NOT use	retired)	0	5 /
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215-0036 be filed within 7 rated Hygiene. rated other than ent, the Medica		17. Father's Name (First, Middle, Last)		ia		me (First, Middle, Ma	iden Surname)	2
D 21215-C should be filed v and Mental Hygi 7 is marked oth	To Be	19a. Informant's Name/Relationship (Type	res Camp	19b. Mailing Add	May	or Rural Route Numb	er. City or Town, State	Zip Code)
MD 21 12 should I th and Mer 127 is man umatic ev	-	1 111	uper		e Avenue L	1 - 2	Naryland 20c. Location - City or	
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition	20b. Pl	ace of Disposition	Name of cemetery,	Date		
MOFE Pages 1 ent of Fr unt: If i		1 Burial 2 Cremation 3 Donation 5 Other Specify:		adise (emetery '	1/10/12	Trappe, Mo	ryland
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus	ď	21. Signature of Funeral Service Licensee	1 2	22. Name	emetery and Address Facility y Funeral washington	Home, P. A	7 -	
	_	23a. Part I. Enter the disease, or complica	lenry	510	washington	St. Canb	ridge, M.	Approximate Interval
Physician /Medical		failure. List only one cause on each	line.			ic or respiratory arres	t, snoot, deneart	Between Onset and Death
xaminer		man Carri to the contract to	herosclerotic Cardiova e to (or as a consequence of):		•	_		- Bouti
		Sequentially list conditions, b						
	<u>ē</u>	if any, leading to immediate Ducause Enter Underlying Cause	e to (or as a consequence of):					
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3760, ficate be executed g physician and s the burial - transit	SalE	d						
O, be ex sician			MENDED					
876 ifficate ng phy ss the t	Ž	23b. Was decedent pregnant in the	23c. If yes, outcome of pregna	ancy 2 Fetal de	ath 3 Ectopic pre	gnancy	23d. Date of delivery Month	ey Year
X 687 ith certific attending	icia	A No. of No. of University	Pregnant at time of deat		Specify)			
D. BO): the death by the att	Physician/Medi	Part II. Other significant conditions co	9 Unknown	ulting in the under	wing cause given in Part I	23e Did toh	acco use contribute to	the cause of death?
, P.O. Eres that the displaying signed by the be detached	<u>a</u>	, are in out of significant conditions	Transacting to death but not res	diang in the dilecti	ying cadoo given iirr air i		2 No 3 Prob	
ords, w require s been si should b	eted				•	– 24a. Was ar		topsy findings available
e law e has t	Completed					autopsy perform 1 ✓ Yes 2	ed? death?	ompletion of cause of s 2 No
tal Rectinn: The certificate ector, page		25. Was case referred to medical			26.Place of Death (Che		No 1 ✓ Ye	s 2 NO
Vita	To Be	examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2 E	R/Outpatient 3	DOA Other Nu	rsing Home 5 R	esidence 6 🗸 Other	Scene
n of ding Ph. After the funeral		27. Manner of Death 1 Natural 5 Rending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
SiOr Vittend death. ctor:	Certification:	2 Accident S Pending Investigation			1 Yes 2 No	000 1 1 1 1 1 1 1 1 1 1		I De to North of O's
Divis	Ĕ	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rura or Town, State)						
Divis Hospital or A 24 hours after Puocral Directed filled in b		29a. Certifier	To the best of my knowledge	e, death occurred a	t the time, date and place, a	and due to the cause	s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: O	n the basis of examination and manner stated.					
F.3 F.8	ŝ	29b. Signature and title of certifier	On a C		29c. License number		29d. Date signed (Mor	nth, Day, Year)
J 1		Carde 14	tellan		O.C.M.E.		January 4, 2012	
		30. Name and address of person who con		-	ro Stroot Baltimore	MD 21222		
	,,,	Carol Allan, MD Assistant 31. Date filed (Month, Day, Year)	Medical Examiner 9		ie olieet, baitimore,	Z 1223		
St Regist	ate rar	IAM O 2 2012	32. Registrar's Signature	Jak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 18, 2012 1:05A M Andrew William Calvello Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Queen Anne Centreville Hospice of Queen Anne's If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1472871956 ^cPennsylvania 1 🖫 M 2 🗆 F Director 55 166-48-8561 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Denton Caroline Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21629 25738 Burrsville Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United State Air Force 12 H.S. Grad. Jet engine mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Sarah Egan John Michael Calvello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Margie M. Calv</u>ello/spouse 25738 Burrsville Rd. Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemeter 1/20/2012 Hurlock, Maryland Moore Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIL Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Litter orderlying Cause (Disease or iinjury Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician; completed filled in by the funeral director, 25. Was case referred to medical Be examiner? 10 Hospital Other: 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2540

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{Ye} Lillian M. Cribben 7:00 Ам Medical January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Renaissance Gardens at Riderwood Montgomery Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 29,1920 Wilkes-Barre, PA **Funeral** 1 M 2 X F Days Hours 91 166-16-5286 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 20904 3160 Gracefield Road, OG-3119 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 I Hygiene. General Accounting Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Bernard Leo McDonnell Margaret Lavin other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Mary C. Murray / Daughter 1931 Kimberly Road, Silver Spring, MD 20903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State cemetery, crematory or other place) Metropolitan Crematory 1/11/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician) Arteriosclerotic Cerebral Vascular Disease Unknown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Soquentially list concidents, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical P.O. Box 68760 ending purchase IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No ō Month Day Year Pregnant at time of death the ned by tle detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b sign be Records, Myeloproliferative Disorder Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown been Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? certificate Yes 2 X N 2 No ☐ Yes **Division of Vital** 25. Was case referred to medical Be 28. Place of Death (Check only one) Hospital: Other: 4 🛛 Nursing Home 5 🗋 Residence 6 🗌 Other (Specify) 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work . .acural ☐ Accident ☐ Suici death. 1 Yes 2 🗆 No s after death I Director; A d in by the fi Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Directory Completed filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

Eileen Gemmell, C.R.N.P., 3160 Gracefield Road, Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

o filed (Month, Day, Year)
JAN 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Emaline Clingerman 1312 01 2012 Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-Regional medical umberland Hilegam If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Director 219-16-0733 92 Yrs. 1 □ M 2 🗓 F PA 10/11/1919 Usual Residence of Deceder f show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2🌠 No MD Little Orleans Allegany 10e. Street and Numbe ò 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or Funeral 21766 IISA 32712 National Pike 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Samuel Martin Joanna Clingerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31813 Old Adams Road Little Orleans,MD 21766 Carl Bailey/Administrator other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Page 1 1 $\[\underline{X}\]$ Burial 2 $\[\Box\]$ Cremation 3 $\[\Box\]$ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 01/20/2012 Fairview Cemetery Artemas, PA 21. Signature Funeral Service Licen e 22. Name and Address of Facility 141 West Main Street MO0260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or comparished shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death RIEN Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal

Medic

29a. Certifier

29b. Signatu

(Check

only one

Registrar

Robustiaam Barrera

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

and title of certifier

an

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

200 Glenn St.Suite 302 Cumberlan, MD 21502

29d. Date signed (Month, Day, Year)

TH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland (Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Jahua Physician/ Mar Josephine Davie 3:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospita Columbia Howard County Greneral Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **Director** 216-24-3731 1 □ M 2 🛛 F 08/27/1929 MD 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Columbia Howard MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 6410 Chell Road 21044 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐No Specify Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Johns Hopkins APL other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lois Harris Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenwood, MD 21738 3318 Sang Road Linda O'Neill - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of I-Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State Elkridge, MD 4 Donation 5 Other (Specify) 01/18/2012 Meadowridge Mem. 21. Signature of Function 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21043 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracranial Physician disease or condition Medical resulting in death) Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) resulting in death) Last physician CERTIFICATION Physician/Medical certificate be P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ for in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an After this certificate has I prior to completion of cause of death? performed Yes 2 No 1 Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural To the Hospital or Attending injury 5 Pending Division fter death. 1 ☐ Yes 2 ☐ No Accident Investigation in by the within 24 hours feer deal To the Funeral Director 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29b. Signature and the of 2012 241699 ne and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Edna Ruth Hill,

31. Date filed (Month

DHMH 17 Rev 06-2011

America

21044

Columbia, MD

5755 Cedar Lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raphael Joseph Dondero, Jr. 2012 6:58 P M <u>January</u> 6, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 577-42-3750 1 X M 2 🗆 F 80 Yrs 8/30/31 Washington, DC Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗆 Yes 2 🖁 No |Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2640 Quiet Water Cove 21401 within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1953-57 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 3 years Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ၉ Raphael Joseph Dondero, Sr. Angela Ward permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire C. Dondero/ Wife 2640 Quiet Water Cove, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 1/9/12 4 Donation 5 Other (Specify) Kalas Crematory Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home neral Service Licenses Signat 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 1 Yes 2 9 Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 376 29d. Date signed (Month, Day, Year) 2001 Medical Plany Amapolis MD 21401 2. Registrar's Signature

Registrar
DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 OMO 044M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number 8. Date of Birth (Month, Day, Year) May 28, 1916 If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 **Z** M 2 □ F Days Months Hours 176-32-4764 95 Director Pennsylvania Usual Residence of Decedent or 28a-f shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Funeral Director or other traumatic event, the Medical Examiner must be notified MD Anne Arundel Arnold 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 535 Bay Hills Drive Arnold USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service Letter Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Domotor Julianna Racz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Joe Domotor / Son 513 Bay Hills Drive Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State Are Figure 1. Are Find the relation of the rel 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Buer the deease, or complications that caused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failing List only one cause on each line. Approximate Interval Betweer net and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or). attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death
Unknown signed by the a d be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Rari 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2 N Hospital or Attending Physician: 24 hours after death. **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending thin 24 hours after death.

the Funeral Director: Aimpleted filled in by the fu Accident

Suicide

Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number un Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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JAN 1

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/0<u>4</u>/5015 Physician/ Month Ol:25 A ™ Ora Dorsey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Hours Director 579-36-6286 1 M 2 X F 70/53/7459 83 DC show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince Georges Ft. Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7306 Webster Turn 20744 NZA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 75 Federal Government Statistical Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important. If Hem 27 is marked any injury or other traumations. မ James Leo Diggs Mary Reddick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9403 Caltor Ln., Ft. Washington, MD 20744 <u> Shirley D. Newman / daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Veterans Cemeterv 07/78/5075 Cheltenham, MD 4 Departion 5 Other (Specify) of Funeral Service I 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd - Camp Springs MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATherosclerote Cardin Varula disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ≅ 9 ☐ Unknown 9 Unknown signed by the PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director. After this certificate has filled in by the funeral director, page 2 performed?

1 Ves 2 No 1 ☐ Yes 2 Æ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2-1 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate; 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending hours after death, 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 801 1-9-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1170/ livingston RV # 10/ff & Ashington MD 20784 Sidner on MICHAG State Registrar

Physician	1 - State Registrar	LLLState of Maryl	Cei	rtificate of			Reg. No. 20	12 0212
	1. Decedent's Name (First, Middle, Last) 2. Da							3. Time of Death
/Medical	ROBERT	ESPOSITO		T		01	09 20	···
aminer	4a. Facility Name (If not institution, g Calvert Memria				r Location of Death Frederick		4c. County of Calver	
ral tor			yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day June 6	h 9 <i>y, Year)</i> 1946 N	Birthplace (State or Foreign Country) ew Jersey
	Usual Residence of Decedent						2710	
once. To Be Completed by Funeral Director	Maryland Calv		. City, Town or Lo Lusby	ocation				10d. Inside City Limits 1 ☐ Yes 2 💆 No
)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	
<u>ra</u>	1336 Golden Wes			20657			United	
by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	12. Was Decedent Ever Armed Forces? 1		Was Decedent of I If Yes, specify Cub 1 □ Yes 2 1 No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)	14. Hace - Black, Specify:	American Indian, White, etc. white
eted	15. Decedent's (Specify only highest of	Education prade completed)	I (Give	dent's Usual Occu	during most of worki	ng	16b. Kind of Busin	ness/Industry
Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire	d)		Archited	ture
Ŝ	17. Father's Name (First, Middle, La		Arc	- III CCC	18. Mother's Name	(First, Middle,	Maiden Surname)	
To Be	Carl Esposito	Calogero Giu			Anna Lo	uise Lo	hr Anna Al	hlborn
	19a. Informant's Name/Relationship		I		and Number or Rura Drive Sac			
	Carl Esposito -						20c. Location - C	
	1 Burial 2 Cremation 3 4 Donation 5 XOther (Spe			osition (Name of matory or other pla Washingt		4/2012		New Jersey
	4 ☐ Donation 5 ☐ XOther (Spe 21. Signature of Funeral Service Lic		. George	2. Name and Addr	ess of Facility Rau			
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n al	23a, Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	an Due to (or as a col	TACE	LU NG	CANCER	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. CHF Due to (or as a co	the Party of the P	5%				
	resulting in death) Last	Due to (or as a co	nsequence of):					
Q		23c. If yes, outcome of p	regnancy				23d. Date	of delivery
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnan☐ Other (specify)	cy			th Day Year
ed by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 31 e of death 51	Other (specify)			obacco use contrib Yes 2 □ No 3	oute to the cause of death?
þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 31 e of death 51	Other (specify)		1 ☐ 24a. Was	Yes 2 □ No 3 an 24b. W pr	oute to the cause of death?
Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner?	4 ☐ Pregnant at tim 9 ☐ Unknown s contributing to death but no	Fetal death 31 e of death 51	☐ Other (specify)	ven in Part I. 26. Place of Deat	1 ☐ 24a. Was auto perfic 1 ☐ Yes	an 24b. W psy promed? de 2 ☑ No 1 l	oute to the cause of death? Probably 4 Unknown ere autopsy findings available for to completion of cause of eath? Yes 2 140
To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	4 ☐ Pregnant at tim 9 ☐ Unknown s contributing to death but no Hospital: 1 ☐ Inpatient	Fetal death 3 are of death 5 let resulting in the use of the second seco	Other (specify)	ven in Part I. 26. Place of Deather:	1 ☐ 24a. Was autoperfc 1 ☐ Yes h (Check only come 5 ☐ Resi	an 24b. W promed? de 2 10 0000 11 000000	oute to the cause of death? Probably 4 Unknown ere autopsy findings available for to completion of cause of eath? Yes 2 100
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To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Ye	Fetal death 3 9 of death 5 It resulting in the use 2 ER/Outpatie 28b. Time of linjury At home, farm, st	Other (specify) underlying cause g ent 3 □ DOA Of 28c. Inji W M 1 [ven in Part I. 26. Place of Deather: 4 ☑ Nursing Hourk? □Yes 2 □ No	24a. Was autoperfic 1 Tyes h (Check only of the check on the che	an 24b. W psy promed? 2 1 No 1 1 one) Yes 2 No 3 1 one) dence 6 □Other how injury occurred	oute to the cause of death? Probably 4 Unknown ere autopsy findings available for to completion of cause of eath? Yes 2 100
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bonnie Lynn Ennis \underline{a}^{M} January 2012 1:53 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico 7959 Parsonsburg Road Parsonsburg If Under 1 Year If Under 2 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. 220-66-2928 **Director** 1 🗆 M 2 🗶 F 55 03/04/1956 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🖈 No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21849 USA 7959 Parsonsburg Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Force Yes 2 X No Black, White, etc. "natural", or 9 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 ₩ Widowed 4 □ Divorced White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Distributor Sales other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman G. Chatham Barbara Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
33027 Old Ocean City Rd., Parsonsburg, MD 21849 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Erika Ennis/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/12/2012 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): buria attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Matural 5 Pending To the Funeral Director: A completely filled in by the f 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the i only one) 29b. Signature apartitle of 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGNE DR, SALLSBURY MD 2/804

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2012 A^{M} 6:50 Virginia В. Elliott January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 614 East H Street Brunswick Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) 577-38-7394 **Director** 1 🗆 M 2 😿 F 80 Yrs June 9, 1931 Washington DC 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Frederick Brunswick o 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral USA 614 East H Street 21716 12, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Yes 2 XNo Yes, Give þ 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry old be filed within 72 med Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Labor Union marked other Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Parker Francis Bridgett should I and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 614 East H. St., Brunswick, MD 21716 Michael Elliott / Son Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/12/2012 cemetery, crematory or other place) 1/12/2011 Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory Stauffer Funeral Home 21. Signatur Funeral Service Licensee 22. Name and Address of Facility 1100 N. Maple Ave., Brunswick, MD 21716 owntres complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on add line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Interval Between Immediate Cause (Final Onset and Death Ph. sician/ weeles monar disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine cause (Disease or injury that initiated events requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Pregnant at time of death 2 K No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Deatl 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best only knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 1-10-1Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Frederick Are Mn 2170/ Zaidi MD 801 TOLL House Sacret 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 12:03 Lois Ann Lipps Edwards Januarv Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Kline Hospice House Mount Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Feb. 10, Days Hours Year) 1937 218-34-3792 Maryland **Director** 1 🗆 M 2 🗶 F 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "nature." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Frederick Frederick 1 X Yes 2 □ No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 19 West Second Street 21701 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) by 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Grace Louise Smith Alton Joseph Lipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 West Second Street, Frederick, MD 21701 Albert Edwards / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 21. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2012 John's Cemetery 21. Signature of Funeral Service Lic Reeney and Bastord PA Funeral Home, MO1473 106 East Church St., Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused shock, or heart failure List only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ancre Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t page 2 s 1 Yes 2 No Yes 2 - No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Y

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 759 PM Physician/ ERNDE FROU ESTER January 2013 Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death 4b. City Examiner Madis BWN Melio WOSHINGON Meritus Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. Country) 214-82-1939 Director 1 🗶 M 2 🗆 F Yrs May 29, 1961 50 Maryland Usual Residence of Deced 28a-f show 10b. County 10d Inside City Limits 10a, State 10c. City. Town or Location with the Maryland Director notified 1 Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ö must be Funeral 23a 130 East Ave. Apt 2 21740 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian. Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 2 X No filed within 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Il Hygiene. life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Truck Driver Pavement Company 10 event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever ဂ္ Page 1 and 2 should be Charles W. Ernde, Sr. Bettu Jane Muers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 11400B Stonecroft Crt Apt112 Hagerstown, MD 21742 Charles W. Ernde, Sr. (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Januaru Smithsburg, Maryland Smithsburg Crematory 4 Donation 5 Other (Specify) 23, 2012 J.L. Davis Funeral Home MO1414 22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptersection/ HARRIGIEMIA disease or condition Medical resulting in death) Examiner FOILUPE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death
Unknown 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 TUMOU JUSIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Small Cell 24a. Was an autopsy has page 2 CIRPHOSIU certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred after death. (Month, Day, Year) Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours at To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License numbe By Les M 0005307 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATON M.D Conter HOSPITO Medical 31. Date filed (Month, Day, Year) **JAN 3** 0 2012 32. Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Marilyn Evelyn Elliott January 08:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Washington Hagerstown 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours 04/09/1930 1 🗆 M 2 🗶 F Director 076-22-6558 81 Usual Residence of Decedent 28a-f shov 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 750 Dual Highway U.S.A. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. If Yes Give 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ! should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Counselor Psychological other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emil William Marklein Florence Schrue11 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22202 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Kathleen Marie Greenberg/daughter 801 15 St. South Apt. 1510 Arlington Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 01/25/2012 | Smithsburg, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Disease Physician/ Chronic Kidney disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hupertension Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or an a consequence of) sician and burial-transil executed erebral 12 Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Mell, tus Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 🗆 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7060396 1123112 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARID MUMPS INC. epal FARID MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FVANS Month ARY 13 Zo12 THOMAS Medical 4a. Facility Name (if not institution, give street and numi 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE BEL AIR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 211-34-8552 5/16/1940 Maryland **Director** 1 🎇 M 2 🗆 F 71 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director PA York Delta 1 Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 2278 Bryansville Road 17314 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Agriculture/ Dairy Farmer/Custodian Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Majorie Elizabeth Switzer George William Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2278 Bryansville Road, Delta, PA 17314 Linda L. Evans/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Siate Ridge Cem. 1/18/2012 Delta, PA 21. Signature of Funeral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Ummy 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, a complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician ause as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death

Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GANGLIA MOVEMENT Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown DISORDER 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No TVANS, Thomas To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058913 January 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESAPEAKE MARYLAN

Registrar

(0)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:40P 2012 Karen Patricia Foley January Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 2 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 1 🗆 M 2 💢 F 224-58-5391 10/5/1943 Washington, DC 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Prince George Upper Marlboro Maryland 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5715 Kenfield Lane 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian "natural", or ite Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Special Education Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth M. Foley, Sr. Patricia Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth M. Foley, Jr./Brother 5710 Kenfield Lane, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/10/2012 Edgewater, MD Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final Onset and Death Physician/ End Stage Renal Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Bacterial Sepsis Sequentially list conditions, Due to (or as a nonsequence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Dementia attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be Urinary Tract Infection Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law Jas autopsy performed? Yes 2 No death? certificate | 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 **X**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. To the Funeral Director, A completely filled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, €0 D 61307 January 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Dawit Mekonnen, M.D. 7600 Carroll Ave. Takoma Park, MD

State Registrar 31. Date filed (Month, Pay Year) 2012

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 10.19 PM **Physician** FRANK BESSIE JAN. 2012 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE George's Cherry LANE Numing Ctr If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Min Hours 1 ☐ M 2 🔀 F Yrs. 05/06/1938 73 577-72-4908 Wash. D.C. Director Usual Residence of Decedent the Manyland 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Y Yes 2 No Director Maryland | Prince Georges Riverdale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5312 Kenilworth Ave 20737 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or iten any injury or other traumatic event, the Medical Exami 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hame Maker Own Hame 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Tom Mitchell Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louis Frank - Son 5312 Kenilworth Ave. Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 01/17/2012 Washington, DC Mt. Olivet Cemetery ' 4 Donation 5 Other (Specify) 21. Signature of Tureral Service Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Artery Cormory عدد دالی disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uscase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Dyslipidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diasetes mellitus 24a. Was an 1 ☐ Yes 2 No CHF or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 s atter death.

I Director: After this d in by the tuneral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 141 2012 D 53411 MD J Shesadri 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox 20715 La # 210 MD Bowle Registra is Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 – For** State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°1′2 4:00 P M Jänuary Logan Eugene Fambrough Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery National Institutes of Health Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min 10-18-1992 255-85-8648 1 X M 2 D F Days Yrs Director GA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No GA Towns Hiawassee 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 2473 High River Road 30546 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene.
7 is marked other than "! Elementary/Seconday (0-12) College (1-4 or 5+) Private <u>Student</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lowell Fambrough Brenda Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 2473 High River Road, Hiawassee, GA 30546 Brenda Fambrough/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Riverdale Park 1-11-2012 Riverdale, MD 4 Donation 5 Other (Specify) Crematory Signature of Funeral Service Lig 22. Name and Address of Facility Pope Funeral Homes, P.A. M01083 5538 Marlboro Pike, Forestville, MD 20747 23a, Part 1. Binter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line Onset and Death Immediate Cause (Final Physician/ 2 1veo12r Diffuse weeks disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic aranulomatus Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and bunial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No မ 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29d, Date signed (Month, Day, Year)

CR 7

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachel Schevaga

P0069249

10 Center Drive, Bethesda, MD

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Fratini Gary 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** at the alisbur comico tospice 7. Age (In yrs. If Under 1 Year If Under 24 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Months 1070571952 Maryland 59 214-62-1208 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 🗌 Yes 2 🗶 No Maryland Wicomico Fruitland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be i Funeral 21826 USA 109 Autumn lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 K No Black White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Senior Engineering Technical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical 12 Advisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mildred Harrison Natel R. Fratini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
109 Autumn Lane, Fruitland, MD 21826 19a. Informant's Name/Relationship (Type, Print) Sharon Fratini/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/11/2012 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service, Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be v. 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Pregnant at time of death Other (specify) signed by the aid be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed 2 No ☐ Yes Yes 2 funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 10 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury work? Natural 5 Pending Accident Investigation completed filled in by the 6 🗌 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the F

3altimore, Maryland 21215

P.O. Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

Registrar

(Check

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SALLSBURY MD Z/804

AMEND #25, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician/ 6:44P M Fenner Sr. ONN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Maryland Medical Center Baltimore City of If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 NC 8. Date of Birth (Month, Day, Sept. 29 Social Security Number Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months 73 Sept. Director 218-34-8283 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 X No Fruitland MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral or items 23a USA 823 Sharp's Point Road 21826 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates "natural", Completed 3 ☐ Widowed 4 🔀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Fruitland Saw Mill 12th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ permit. Page 1 and 2 should be Department of Health and Ment Important. If item 27 is marke any injury or other traumatic eonce. Lena Rebecca Littlejohn other traumatic Moses Windfort Fenner, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 823 Sharp's Point Road - Fruitland, MD 21826 Carol L. Fenner/ Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan UMC Cemetery 01/11/2012 Princess Anne, 4 ☐ Donation 5 ☐ Other (Specify) re f Funeral Service License 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Retroperationeal Physician rematom a disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Weets replacement Infected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be 近く七の名 Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 within 24 hours after death.

To the Funeral Director, After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1X Yes 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 \square Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 1639481476 person who completed cause of death (Item 23a) (Type, Print) 30. Name and 5+ Bultimore 5 Greene Registrar's Signature 31. Date filed (Month, Da 32. State 2 Registrar

per FD 1-11-12 de - State Registrar State of Maryland / Department of Health and Mental Hygiene AACO Health Dept. Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ 2:33 P M 2012 January Miriam L. Godsev Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min **Director** 1 🗆 M 2 🗓 F 88 8/1/1923 Virginia Usual Residence of Decedent items 23a or 28a-f show her must be notified at within 72 hours after death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Anne Arundel Edgewater 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral USA 87 Stewart Dr., Apt. 315 21037 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner or p Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 alth and Mental Hygiene.
127 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Department Store Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Dulanev Mary Elizabeth Logwood 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health an. Important: If item 27 is n any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Haskell Drive, Arnold, Maryland 21012 Marilyn G. Dooley/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 1/6/12 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) soure Medical ue to (or as a consequence of) Examiner boure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural injury 5 Pending Accident Investigation Funeral Director: / 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson AMC Annone 31, Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10, 2012 6:25P M January Sylvester Rov Greisler, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Frederick Mount Airy 8. Date of Birth
(Month, Day, Year)
Jan. 25, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours 1932 Pennsylvania 79 Director 163-26-7245 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a State 10b. County 10c City Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X☐ No Maryland Howard Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 1360 St. Michael's Road 21771 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Architect of the f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Capital Supervisor other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Roy Sylvester Greisler Consuela Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Dorothy Greisler - Wife 1360 St. Michael's Road, Mount Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I-Important; If ite any injury or oth cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State Poplar Springs Cemetery 1/13/12 Mount Airy, Maryland 4 Departion 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Fur
26401 Ridge Road, Damascus, Signature of Filteral Service Licenses Funeral Home us, Maryland Covert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical nsequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Diserte for as a punsuovience offi Cause (Disease or injury the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year 4 Pregnant Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 X No 1 Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle X\) Other (Specify) \(\triangle A\) Hospice 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending s after death. Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide determined filled in within 24 hours a

To the Funeral C

completely filled Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

9

State

7th Street,

15 West

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Alan H. Rohrer,

31. Date filed (Month, Day, Year)

D37197

January 12, 2012

Frederick, Maryland 21701

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9:56 AM Physician/ Month GROSS ROBERT Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death CRESCENT CITIES CENTER RIVERDALE GENESIS 5. Social Security Number 4109 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Hours Min. 213-24-4107 82 MD **Director** 1929 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Temple Hills PG 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 4100 Rocky Mount Dr. 23a 20748 U.S.A. items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married o þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give 1951-1953 Year or Dates. "natural" 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 Hygiene. Elementary/Seconday (0-12) 1 2 Government College (1-4 or 5+) Clerk is marked other Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy,
Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Holton R. Briscoe ဂ္ Annie Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) 20772 Kim Broadie(Daughter) 12704 Marlton Central Dr. Upper Marlboro MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MD National Cem 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-2012 Laurel MD any injury Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral 908 Kennedy St. N.W. Wash, Frency 20011 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MULTIPLE MYELOMA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🗖 Unknown cate has been sig page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Norsing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 \square Pending injury 2 🗆 No within 24 hours after death To the Funeral Director: A Accident Investigation 3
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

the

State Registrar

DHMH 17 Rev 7/2009

Certifying Nurse Prantioner: To the best of my knowledge, death per

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M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

of certifier

HUSA

29b. Signature ar

ed at the time, date and place, and due to the c

29d. Date signed (Month, Day, Year)

1-10-12

RIVERDALE MD 20737

29c. License number

EAST WEST HWY,

Registrar

State

Name and address of

Date filed (Month, Day,

Year)

JAN 0 9 2012

316 Railroad

1064 122

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

AMZIBEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9:03 OLM Physician/ LOUISE GILL Leola 2012 Januar Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON HAGERSTOWN MERITUS HEALTH 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthdav) **Funeral** Days Hours NEW YORK 1 DM 2 XX 86 184-20-6709 Director Usual Residence of Decedent 23a or 28a-f show st be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director INWOOD 1 Yes 2 X No WV BERKELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 25428 and Mental Hygiene. is marked other than "natural", or items 23s aumatic event, the Medical Examiner must I 167 1ST STREET Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16h, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME **HOMEMAKER** Be 18. Mother's Name (First, Middle, Maiden Surname)
LEANORA BELL SEGER 17. Father's Name (First, Middle, Last) ပ္ IRA MERRILL GROVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 333 MONTMORENCY DR., BUNKER HILL, WV 25413 BRENDA GILL-KEAR/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition JAN. 21, 1 Burial 2 Cycremation 3 Removal from State 4 Donation 5 Other (Specify) SMITHSBURG, MD SMITHSBURG CREMATORY 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 76 327 W. KING ST. MARTINSBURG, WV 25402 Ida 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician disease or condition Medical resulting in death) Due to (or as a consequency of) Examiner ona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last as the burial-1 Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 2 prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 - ER/Outpatient 3 - DOA မ 1 🔲 Yes After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending injury Natural within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and one of the date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one e and the of cert 29d. Date signed (Month, Day, Year) 29b. Signati 2

Registrar
DHMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	State of N		d / Depa	artmen		alth and M	1ental Hyg	jiene	gible.	0011.1
Physicia Medic		1. Decedent's Name (First, Middle, La	A A.	H	166	S	OI Dea	1111	2. Date of Dea	th	2011	3. Time of Death <i>C 930</i> M
Examin		4a. Facility Name (if not institution, given Tate Hospice Hou	,				own, or Loca hicum	ation of Death			ty of Death Arund	
Funeral Director		5. Social Security Number 6.	Sex 7. A	ige (In yrs. la	ast birthday) Yrs.	If Under Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 2/6/195	Year)	9. Birthp Count Mich:	**
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ector	10a. State 10b. County Virginia Fairfax			y, Town or Loc ngfiel							0d. Inside City Limits 1 ☐ Yes 2 ※ No
	Funeral Director	10e. Street and Number 7504 Nancemond St	treet			10f. Zip 221				10g. Citizen of USA	What Coun	try?
	by	11. Marital Status 1 Narital Status 1 Narried 2 Narried 3 Nidowed 4 Divorced	12. Was Deceden	?	- 11	Yes, speci	ent of Hispan fy Cuban, Mi	nic Origin? (Spe exican, Puerto pecify:	ecify Yes or No- Rican, etc.)		ack, White, e	etc.
	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		r 5+)	(Give k	aind of work O NOT use	retired)	n g most of worki	ing	16b. Kind of I		·
d be filed v dental Hyg arked oth aric event,	To Be	17. Father's Name (First, Middle, Last, Robert Neall Hil					,		e (First, Middle, I arlotte			
nd 2 shoul salth and I n 27 is ma er trauma		19a. Informant's Name/Relationship Robert N. Hills/			1				Route Number, Edgewat			
Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		C C	lace of Disposemetery, crem	sition (Nam	e of her place)		Date /2012	20c. Location	- City or To	wn, State
permit. Departi Import any inji		21. Signature of Funeral Service Lice	falu h	`	²² 29	. Name and	Address of 1 Address of	Facility Geo:	rge P. H d Rd. Ed			
Physician/ Medical		23a. Part 1. Enter the disease, or conshock, or deart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that days one cause or each line. a. Due to (or a	ne. C =	K O		of dying, su		or respiratory arre	est,	u	Approximate Interval Between Onset and Death
Examiner question and the state of the state	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequ	uence of):							
e be executed ysician and ne burial-transit	ical	that initiated events resulting in death) Last	Due to (or a	s a consequ	ience of):							
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live Birtl 4 ☐ Pregnant 9 ☐ Unknown	n 2 ☐ Feta at time of c	l death 3	Ectopic po Other (spe					ate of delive	ery Day Year
requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying c	ause given ir	n Part I.	23e. Did to			e cause of death?
The law requ ate has been page 2 shou	Completed								24a. Was a autop: perfor 1 Yes			osy findings available mpletion of cause of
sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:				Other:	of Death (Check	only one)			1815
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate: To	1										HOUSE
ital or Atte Ins after de al Directo led in by t		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)				et, factory,	office		28f. Location (Si City or Town		ber or Rural	Route Number,
the Hospi hin 24 hou the Funer npletely fil	Medical	(Check 2 Medical Exar only one) 3 Certifying Nu	ysician: To the best niner: On the basis of rse Practitioner: To	examination	n and/or invest	igation, in m	y opinion, de	eath occurred at	the time, date ar	nd place, and di	ue to the cau	use(s) and manner stated.
with Voc		29b. Signature and title of certifier Welf	Jatens	2 A	21	9	License num	170	17	29d. Date sign	ed (Month, E	7. 2012
H10.		30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	rint)	EFFA	USFA	ev v. de.	WAPOL	fr by	121401
Stat Registra		31. Date filed (Month, Day, Year) JAN 0 9	2012 32. Reg	tlar's Signat	ure A.	park	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 State
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0740 2012 Harry R. Hornberger, Sr. Vanuary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fastun Talbot Memorial Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 218-44-1859 65 Mar. 31, 1946 Director 1 X M 2 □ E Maryland Usual Residence of Decedo 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ms 23a or must be n Funeral USA 21601 29141 Superior Circle items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. "natural", or iter edical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturnary injury or other traumatic event; the Medical Bone. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Public Safety Fire Fighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Elizabeth Miller Clarence Hornberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Easton, MD 21601 29141 Superior Circle Patricia Hornberger/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. Date 9, 1 Burial 2 Cremation 3 Removal from State 2012 Baltimore, MD 4 Donation 5 Other (Specify) Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part r. Enter the efficace or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart all efficiency are such as cardiac or respiratory arrest shoot, or heart all efficiency are such as cardiac or respiratory arrest shoot. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lntracrania disease or condition resulting in death) Medical Due to (or as a consequence of) *E*xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): CERTIFICATION APPROVED the burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last ohysician Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Vear Day Pregnant at time of death 1 Yes 2 g Unknown q 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 shknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has autopsy performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 X Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ပ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Subject fell Certificate: After injury 1 Natural 5 Pending and hit head on cabinet 12/29/2011 1 Yes 2X No **Unknown**^M 2 X Accident Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29141 Superior Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Home Circle, Easton, MD Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dog 5 Jan

Registrar

State

tonburer, Harry

5. Washington St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day, Year)

JAN 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 PerFH G925 3/12/2012 JH
State of Maryland / Department of Health and Mental Hygiene

1 = For State Amend Item 25 per me,g924,02/15/2012dhb
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

The Amend Item 25 per me,g924,02/15/2012dhb
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Maru Bernadette Month Year Physician/ 0027 M 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Howard Columbia 5. Social Security 16914 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 219-40-6134 Director 1 🗌 M 2 🔀 F 72 10/28/1939 MD Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Funeral Director 1 🗌 Yes 2 🔀 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Ь ms 23a or must be n with 1 8801 Bosley Road Unit #401 21043 United States items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Armed Forces? Black, White, etc. ò 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: "natural" 3 X Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Bank Teller Banking Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Andrew Miller, Jr. Catherine Alice Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Paul Hennick - Son 3722 Bonny Bridge Place Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/19/2012 | Eldersburg, MD Lakeview Cemetery Sunatury of Funeral Service Lyensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intracerebral Physician. hemorrhad disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consumence of burial-transi Cause (Disease or injury that initiated events resulting in death) Last and CERTIFICATION Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be-P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 XYes 1 ☑ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 00066511 2012 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Pegistrar's Signatur State JAN 1 Registrar -euch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registra Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:32A HOLIBAUGH GAUBERT Physician/ JANUARY ENID Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** Days 433-42-8570 1 M 2 AF Feb. 3, 1930 Louisiana Director 81 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County must be notified at **Funeral Director** 1 🗌 Yes 2 🔀 No 28a-f Monrovia Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō United States 21770 23a 4001 Tranquility Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after death 12. Was Decedent Ever in U.S. Black, White, etc. "natural", or itel Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married þ ☐ Yes 2X No Specify Baltimore, Maryland 21215-0036 White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Veronica Naquin မ Sylvester Gaubert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4001 Tranquility Court, Monrovia, Maryland 21770 permit. Page 1 and 2 shu Department of Health ar Important: If item 27 is any injury or other trau once. Denise Holibaugh/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Stauffer Crematory Inc. 1/12/2012 Frederick, Maryland. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signatur Juneral Servi Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Shock Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions Due to (or as a consequence of Examiner if any leading to immediate cause. Enter Underlying 2 ilus N ba as the burial-transit Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last attending physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Month Vear in the past 12 months? Pregnant at time of death by the a 9 Unknown 9 Inknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ been signed þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No has 26. Place of Death (Check only one)

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 this certificate the funeral director, 25. Was case referred to medical Be Other: 1X Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 Yes 잍 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Certificate: Director: After 5 Pending X Natural Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after or To the Funeral Direct completely filled in by filled in by 4 Homicide To the Hospital Medical 29a. Certifier (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DI

Year)

Date filed (Month,

28f. Location (Street and Number or Rural Route Number, City or Town, State) LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number Frederick MD, 21701

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Registrar

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 11.20 A M Josephine L. Harrison Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPICAL BALTIMORE ST AGNES N/A If Under 1 Year | If Under 24 Hrs. | Hours | Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F Nov 15 1958 Maryland 216-82-6722 53 **Director** Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 8136 Phirne Rd. 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or ite Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: B1ack If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12th None None Be 17, Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည Josephine Brown Richardson Harrison permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Morgan(Sister) 8136 Phirne Rd. East Glen Burnie, Md.21061 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 1-11-12 Brooklyn Park, Md. Windows Record & Cili Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Zavr 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DNEUMONIA Immediate Cause (Final Ph, i i n disease or condition Medical resulting in death) Due to (or as a consequence of): Munn Examiner INFECTION URINART TRACT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): Physician/Medical 68760 use as 1 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) signed by the at d be detached fo 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DIAGETED MELLITUS Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No STRURE DISMOFA 24a, Was an autopsy page 2 RETARDATION MENTAL Yes 2 No Vital 25. Was case referred to medical or Attending Physician: director, 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 ER/Outpatient 3 DOA မှ this funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After upleted filled in by the funer iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

7 H ARRISO Division of Hospital

JOSEPHN

State Registrar

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Pay Year) 1 2012

within 2.

To the F

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ACCEMDING

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAME TAMINAS 3 Y JT WILLEN

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: to the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10056948

29d. Date signed (Month, Day, Year)

2012

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29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:35 AM CHARLENE YVETTE HILL January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-80-4041 Director 1 □ M 2 🛚 F 03/01/1963 MD 48 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City. Town or Location Director ¶ Yes 2 ☐ No MD Germantown Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20876 11321 Stevenson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) ould be filed within 72 nd Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed 12th Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Powell Joseph Riggs should to and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh rment of Health a tant: If item 27 is 11321 Stevenson Drive, Germantown, MD 20876 Angel Lyles/daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 01/20/2012 Sandy Spring, MD 4 Donation 5 Other (Specify) Ash Memorial Cem 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Juneral Service Lickn 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Pseudomonas preumonia Immediate Cause (Final Physician/ resistant disease or condition resulting in death) - drug Medical Due to (or as a conseque of of) Examiner hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine nding physician and use as the burial-transit uires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760
To the Hospital of Attending Physician: The law requires that the death certification the Funeral Director. After this certification of the North Completely filled in N IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ▼ No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 12 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nursa Fractition in To the best of my knowledge seath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bichhum D54996 M

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Morty, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bickhuenc M. Vinh 18101 Prince Philip

January

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 5, 2012 ear Physician/ Vincent J. Hearing 8:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 578-22-3564 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours 06/18/1923 Director 1 XM 2 □ F 88 New Jersey Vrs ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director MD Montgomery Gaithersburg 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 407 Russell Avenue 20877 United States Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. 11. Marital Status Examiner Was Decedent Ever in U.S.

Armed Forces?

1 ▼Yes 2 □ No 1947—

If Yes, Give

Year or Dates. 1966 Black, White, etc 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 nan "natural", 1 Yes 2X No Specify: Specify: White 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Executive Law Firm the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eleanor Gallagher traumatic Vincent Hearing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is r. any injury or other traum once. Christopher Hearing / 4928 Jasmine Dr. Rockville, MD 20853 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4-24-2012 Arlington Nat. Cemet. Arlington, Virginia 21. Signature f Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. Mospie 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CPhysician/ disease or condition Renal Failure <u> Hours - Days</u> Medical resulting in death) **Examiner** Pneumonia Days Sequentially list conditions Examine Due to for as a consequence on in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events n and Lyransit Aortic Stenosis Years Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Year Month Pregnant at time of death g Unknown 9 Unknown been signed by to should be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 XN 1 Yes 2 No Vital å 25. Was case referred to medical 26. Place of Death (Check only one) 2**X** No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 1 🗌 Yes Certificate: the Hospital or Attending 1 XNatural 5 Pending Division 2 🗌 No within 24 hours after death

To the Funeral Director: A

completely filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and titl

of certifier

Keith Horvath MD 8600 Old Georgetown Road Bethesda, MD 20814 31. Date filed (Month, Day, Year) JAN 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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01/05/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hernundez Year 7 11:29 odolinda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DING montgomer montgomery Heneral 1105121121 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) **Director** 1 □ M 2 🗓 F 77 May 8, 1934 El Salvador "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shor 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 3308 King Williams Dr. El Salvador 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc ģ 1 X Never Married 2 Married Specify: Latino 1 🛚 Yes 2 □ No Specify: Salvadorian Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Own house Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Eliseo Hernandez Ubalda Fuentes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maribel Hernandez (daughter) 3308 King Williams Dr. Olney, MD 20832 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Response Proceedings of the Control 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 $\overline{\mathbf{X}}$ Removal from State 01/17/12 San Salvador 4 Donation 5 Other (Specify) 22. Name and Address of Facility 600 Kennedy ST, NW.: Washington, DC Signature of Funeral Service Licensee 20011 Santa Cruz Funeral Services, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ respiratory disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 116/2012 Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 116/2012 ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit pheummia To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No completely filled in by the funeral director, i Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00070921 8/742 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) VIMINIA Sherly, MD 18101 Pnna MILLIA Drive Olycy mo 70832 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANU ARU Physician/ 1125 AM Arthur Valentine Hillyard Medical . County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) **Director** 215-20-4068 1 🕱 M 2 🗆 F 86 Sept. 19, 1925 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director be notified 1 X Yes 2 No MD Prince George's College Park or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 4818 Erie Street 20740 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 💮 A1 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 1944-45 traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) **PEPCO** Lead Mechanic Substation Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ဂ္ Arthur Valentine Hillyard Margaret B. Stailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Dorianne H. Folstein / Daughter 1541 Eton Way, Crofton, MD 21114 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 1/17/2012 | Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Bruse Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Obstructive pulmonory disease Onset and Death Immediate Cause (Final hronic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗹 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

izzoo Annapolis RO, Sutezza Glen Date, MD 20769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abde 119, mo MUKEMIL

muterial Abdelia, und

29b. Signature and title of certifier

29c License number

D0059981

29d. Date signed (Month, Day, Year)

1115/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 8:13 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Charter House Assisted Living If Under 1 Year If Under 24 Hr 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔀 F Hours Year) Days (Month, Day, 16, Director 218-06-0371 87 Guyana Aug. Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 🖾 No MD Silver Spring Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 23a r Funeral 72 hours after death with 20910 USA 1316 Fenwick Lane, Apt. 407 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Completed Multi-racial Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Mildred Nicholls Ernest McKenzie other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Carol Hazlewood / Daughter 4212 Rainier Avenue, Mt. Rainier, MD 20710 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗵 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 1/17/2012 Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) + MI Medical ue to (or as a consequence of) Examiner VASCULAR Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying consequence of that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Cother (specify) in the past 12 months? Month Year Pregnant at time of death 9 Unknown the P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform has death? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medica To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ALF 4 Nursing Home 5 Residence 6 Nother (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred s after death. Certificate: injury 1 X Natural 5 Pending ☐ Accident☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted (Check within 2

To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) January 13, 2012 D37142

DHMH 17 Rev 7/2009

State

Registrar

1355 Piccard Drive, Suite 100, Rockville, MD 20850

30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

Geoffrey Coleman,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:35PM Hyre 2012 Leonard Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. Citv. Town, or Location of Death 4c. County of Death Examiner Jasta1 11561 Uicomico Hospice O+ If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 F (Month, Day, Year) 04/15/1944 Months Davs Hours 233-70-5985 67 Director West Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō : If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be Funeral 21804 USA 103 Village Oak Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration 12 Claims Representative Be Page 1 and 2 should be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Alma Jean Watson Leonard Lincoln Hyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Village Oak Dr., Salisbury, MD 21804 Nancy J. Hyre/spouse Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/13/2012 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21904 permit. 21. Signature of Funeral Service Pronsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANCREATIC NAN disease or condition resulting in death) MAZIE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and defached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/1 No 1 Tes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was an autopsy performed After this certificate has death? 2 10 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 408PICE Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending iniury work? 2 No Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 -3 [only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1105 M Eddie Hampton TAN 07 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner HICOMICS CIONAL MICAL If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 228-72-6766 Director 1 X M 2 □ F 59 6-25-1952 VA Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes X No Salisbury Wicomico MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 1010 E. Road, Apt 101 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Bace - American Indian Medical Examiner Black, White, etc. ō þ 1X Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates SpeciBlack "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Cab Business Driver and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Thomas Evelyn Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21851 Important: If item 27 any injury or other tra Delphia Reid/Sister Apt 1 Pocomoke City, 410 Market Street, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other hards 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 1-16-2012 Dover, DE Billy 917 W. Isabella St. tun of Funeral Service Licensee Bennie Smith once, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b page 2 autopsy 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes ပ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending iniurv Natural 1 Yes 2 No Accident Investigation completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one

State Registrar 29b. Signature and title of certifier

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

V Cer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia		Decedent's Name (First, Middle, Last) Bonnie Jean Hubbard				2. Date of Dea	ath Day	laar	3. Time of Death		
	Medic Examin	_	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c.							Ac. County of Death ### County of Death		
	Funeral Director		1-	7. Age (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Year)	9. Birthplac Country)	e (State or Foreign		
100		or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		April 2	28, 1948	Mary 10d.	Land Inside City Limits		
	ie Maryla ir 28a-f s notified	Director	MD Wicomico 10e. Street and Number	Fruitla	and 10f. Zip Code			10g. Citizen of Wh	et Country	1 🖾 Yes 2 🗆 No		
	h with the ns 23a o	Funeral	326 Holiday Street			21826		_	5.A.			
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 24a or 28a-f show aumatic event, the Medical Examiner must be notified at	<u>م</u>	Armed Force 1 Never Married 2 Married 1 Yes If Yes, Give	ces? 2 X No	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white			
21215-0036	72 hours "natura ledical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupa e kind of work done de DO NOT use retired)		ng	16b. Kind of Busi				
212	d within ygiene. her thar nt, the M	Be Con	Elementary/Secondary (0-12) College (1-4	4 Or 5+)	memaker				me			
Maryland	should be filed n and Mental Hy 7 is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last) Gene T. Willey			18. Mother's Name	e (First, Middle, nia Bar					
	12 shoul lith and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Virginia Garrison (Daugh		iling Address <i>(Street a</i>				te, Zip Cod			
Baltimore,	oermit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from S	20b. Place of Disposition Commetery, critical Commetery, critical Commetery, critical Commetery, critical Commetery, critical Commeters and Co	position (Name of ematory or other place	1-13-	Date	20c. Location - C				
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09	ate be executed ohysician and the burial-transit	edical E	resulting in death) Last Due to (o	or as a consequence of):								
6876	sertificate Iding phy Ise as th			come of pregnancy				23d Date	of delivery			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)	У		Mont		y Year		
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the check only one (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the check only one (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the check only one (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the check only one (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the ch								and place, and due t the cause(s) and ma	o the cause nner as stat	ed.		
	8 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		29b. Signature and title of certifier	5	29c. License	/		29d. Date signed (Month, Day	(, Year)		
	30			of death (Item 23a) (Type	, Print) 5f. 4	140713 AUSBUU	', MO	2/80/1	SHOVER	I Hearde, m.		
ī	Sta Registra		31. Date filed (Month) 4 Near 2 2012 32. B	sistrar's Signature	pare							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PRISCILLA M. HITCHCOCK Day Physician/ Month 19,2012 1:45A Medical Jan. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Senator Bob Hooper House Forest Hill Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 08/31/1943 218-40-6924 **Director** 1 □ M 2**X** F 68 NC 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified Street MD Harford 1 Yes X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a o must be 3307 Forge Hill Road 21154 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ò þ 1 Never Married 2X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify White Specify: "natural" Completed 3 Widowed 4 Divorced 16b. Kind of Business/Industry Center 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working lite DO NOT use ratired) Personal Secretary $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10 \end{array}$ College (1-4 or 5+) Rehabilitation the other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Arthur C. Ashley Molly B. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Posd Street, MD 21154 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important; If item 27 is any injury or other trau 3307 Forge Hill Road, Street, MD Arnold C. Hitchcock/Husb. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Harford Mem.Gdns. 1/23/2012 Aberdeen, MD Signature of Funeral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final Onset and Death Ph, i i n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn 2 No Yes Vital To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and Ale of certifier pleted cause of death (Item 23a) (Type, Print) 2300 DULANGY 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jahuary 20%, 2012 7:00A. M Wendell Holmes Headley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Linthicum Anne Arundel Tate Hospice House Social Security Number 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) July 2, 1933 1 XM 2 □ F 577-44-4515 78 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Beltsville Maryland Prince George's 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4803 Brandon Lane 20705 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 1953-1955 Year or Datas 953-1955 and Mental Hygiene. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morgan Starke Headley Irma Louise McGinness other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar.
Important: If item 27 is any injury or other traumone. 4803 Brandon Lane Beltsville, Maryland 20705 Gertrude B. Headley - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ballowith Memorial Methodist Church Cenetery 1 X Burial 2 Cremation 3 Removal from State 1/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Millersville, Maryland 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Colo-rectal Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours after To the Funeral Director Completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Relle D23743 20, 2012 nant January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martin Weltz, M.D. 7525 Greenway Center Drive, #205 Greenbelt, Maryland 20770 JAN 3 0 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ Year JIMMY MACK HODGE 12:55 P 19 JAN. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE ST. THOMAS MORE MEDICAL CENTER HYATTSVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 🗆 F Months Hours (Month, Day, Year) 411-54-7498 TENNESSEE 74 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director W۷ BERKELEY BUNKER HILL 1 Tyes 2 X No 10f, Zip Code 10e Street and Number 10g. Citizen of What Country? 25413 Funeral 121 MOCKINGBIRD CIRCLE USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.

7 is marked other than "r traumatic event, the Med E.I. DuPONT Elementary/Seconday (0-12) College (1-4 or 5+) FORKLIFT OPERATOR Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) DELLA JANE BENTON LAWTON WILLIAM HODGE permit. Page 1 and 2 should be Department of Health and Men. Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 247 OLD MIDDLEWAY ROAD, KEARNEYSVILLE, WV 25430 JAMIE LYNN HODGE/GRANDDAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State JANUARY 24, MIDDLEWAY MASONIC CEM. MIDDLEWAY, WV 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, PO BOX 821, 22. Name and Address of Facility 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysicianz HRTEGIOSCLEROTIC CARDOVACULAR DISCOVE PANS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Dusito for sels hunerausines of if any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav signed by the and be detached for g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Whease · Coronary Artery Wisease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Chronic Obstructure Polmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Diabetes mellitus itypentensions Yes 2 X No Division of Vital 25. Was case referred to medical After this certific funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

32. Registrar's Signature

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veensbury Rd Hyatteville MD 20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2012 Physician/ Mary F. Ingalls P M 7:46 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Months Hours Min (Month, Day, Year, 135-16-3186 1 🗆 M 2 💢 F **Director** 89 July 1, 1922 | North Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at Director 1 ☐ Yes 2 ☑ No Frederick Maryland Frederick 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be 21704 Funeral USA with 23a 5955 Quinn Orchard Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Examiner Black, White, etc. 1 Yes 2 No WWII If Yes, Give Year or Dates. ö þ 1 Never Married 2 Married be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify "natural" 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ± 2 Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot ir other traumatic ever ပ LuLu Brannin Walter DeFriest Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2564 Log Mill Court, Crofton, MD 21114 Elizabeth Ingalls / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 1/11/2012 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknowh 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has I autopsy performed? Yes 2 No certificate Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice House ဂ္ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this Medical 🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only on 29b. Signa und title of certifier 29c. License number 29d. Qate signed (Month, Day, Year) D51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ろ Thouson H7x50 05 Thomas 20 Day, Year) 32. Registrar's Signature JAN Registrar DHMH 17 Rev 06-2011

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AMEND #25,27,28A-F, PER ME G929 // 17/12 TRT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 16^{ay} 201^{rea} William Albert 2201 p Ireland, Jr. January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Chester River Hospital Center Kent Chestertown 8. Date of Birth (Month, Day, Year) Nov 27 1983 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 X M 2 - F Hours Min. Dover Director 213-06-6288 28 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Examiner must be notified 1 Yes 2X No Maryland Queen Anne Centreville 10e. Street and Number 10f. Zip Code 23a or 10a. Citizen of What Country? by Funeral 3009 Price Station Road 21617 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Oppartment of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William A. Ireland, Sr Karen Schmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Schmitt/ mother 3009 Price Station Road; Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greensboro Cemetery Jan 20 2012 Greensboro, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONUFO BY MEDICAL EL Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autopsy perform death? 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 🕱 No Accident death. 1/16/2012 UNK P SUBJECT CHOKED ON PILLS Investigation after death Director. 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State 3009 PRICE STATION ROAD, CENTREVILLE, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined HOME Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Queenstown receau 31. Date filed (Month, Day, Year) 32. Registrar's State JAN 1 9 201 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security No. 220–18–50		6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (Sta Country)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Day Year JOHNSON HER WOLLEY Αм 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** George's 7306 Joplin Street Seat Pleasant Prince 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace Country) **Funeral** 10-4-1930 1 □ M 2 🗓 F Hours 577-42-0306 Director SC 81 Usual Residence of Decedent or 28a-f show le notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director 1 Yes 2 ☐ No MD Prince George's Capitol Heights 10e, Street and Number 10g. Citizen of What Country? "natural", or items 23a o permit. Page 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Funeral 20743 US 7306 Joplin Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Statistical Clerk Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Wolley Julia Jamison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7306 Joplin Street, Capitol Heights, MD 20743 Evlance B. Johnson/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 xBurial 2 Cremation 3 Removal from State 2-1-2012 Arlington Cemetery Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Lig 10108 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 0101 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manyler of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No M Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 LIPPMANMO C7 Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^Df 2 0 9 2 Jamuary Goldie Leornet Jackson 10:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Health Care-The Pines Talbot Easton 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 Days Hours Maryland Min (Month, Day, Director <u> 220-10-6598</u> 93 08/23/1918 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director Bethlehem 1 Tes 2 No Caroline MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 22101 Tanyard Road 21609 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Jackson 121215-0036 Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) J Mental Hygiene. marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Seaford Factory Worker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Elliott Martha Elliott item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 735, Easton, MD 21601 Sheryl L. Groce/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ± 5 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Federal Hill Cemetery 01/21/12 Federalsburg, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onet and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Was decessing the past 12 menth of the past 12 menth of the Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Diabetes mellifus Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CROWLEY

MICHAGI

31. Date filed (Month, Day,

		1- For State Registrar		ficate of Dea	ath	,,,	Reg. I	No. 2012	0216	
Physicia fedical Exami	an/	1. Decedent's Name (First, Middle,L	Jackson Sr.			J.	Date of Death Month Da anuary 18, 2	2012	3. Time of Death 1920 hrs	
		4a. Facility Name (if not institution, of 12480 Harvey Road		Cle	r, Town, or Location ar Spring			4c. County of Death Washington		
Funeral Director		219-78-8236	Sex 7. Age (In yrs. last 49		nder 1 Year If Un oths Days Hou		. Date of Birth (N	MM/DD/YYYY) 9. Birti -1962 Foreign Cou	nplace (State or PA n PA intry)	
Aaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State MD 10b. County Wash		own or Location ear Spri	ng				10d. Inside City Limits 1 Yes 2 No	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number 12480 Harvey	Rd.	10f. 2	Zip Code 21722			Citizen of What Coun	try?	
	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	1 Yes 2 No ed If Yes, Give Year or Dates:	If Yes, spe	dent of Hispanic O ecify Cuban, Mexica 2 X No specif	an, Puerto Rica fy:	an, etc.)	14. Race - American Indian, Black, White, etc. white Specify:		
b, MD 21215-0036 and 2 should be filed within 72 hours after fealth and Mental Hygiene. item 27 is marked other than "natural", transmatic event, the Medical Examiner	mpleted	15. Decedent's Education (Specify Elementary/Secondary (0-12) 12th grade	College (1-4 or 5+)		vorking life. DO NO uction	Tuse retired) /carpe	enter	b. Kind of Business/Ir Constru		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be	17. Father's Name (First, Middle, La William F. J			D	oroth		se Chane		
MD 21 id 2 should alth and Me in 27 is ma numatic ev	욘	19a. Informant's Name/Relationship Diane M. Jac	kson wife	12480	Harvey	Rd. C	lear S	r, City or Town, State, pring, M	D 21722	
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	Removal from State Lff	ace of Disposition (Name of ROS	ළී Hill	1-24	, 2012	MD	Spring.	
Bal permi Depar Impo	4	100	Mo141	4 Dona	Id Edwi	n Thoi	mpson	Funeral	Home, Inc	
Physician /Medical	01 0	23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease	mplications that caused the death. Deach line. a. Cocaine Intoxio		e of dying, such as	cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death	
Examiner		or condition resulting in death)	Due to (or as a consequence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):							
ecuted and transit	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
760, cate be execut physician and he burial - tra	Medical	₩ UNPENDED	X AMENDED Item 1 as	noted,23a	1,27,28a-	f,per 1	me,g924	2-8-12 sm		
ox 68/ ath certifi attending or use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome of pregna 1 Live birth 4 Pregnant at time of death wn 9 Unknown	2 Fetal dea		pic pregnancy		23d. Date of delivery Month D	ay Year	
i, P.O. Bo ires that the de signed by the I be detached f	ā	Part II. Other significant condition	s contributing to death but not resu	ulting in the underly	ing cause given in l	Part I.		cco use contribute to t		
Records, The law require fificate has been si	Completed						24a. Was an autopsy performe 1 Yes 2	prior to co d? death?	opsy findings available ompletion of cause of	
ital Rec sician: The s: certificate irector, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient 3	26.Place of Deat			sidence 6 🗸 Other:	Scene	
of Vital ling Physician After this certifuneral directo	on: To	1 Yes 2 No 27. Manner of Death		28b. Time of Injury	28c. Injury at Wo	ork? 280	d. Describe how	injury occurred	0.0	
Division tal or Attendiu rs after death. Al Director: A	catio	Natural 5 Pending 2 X Accident Investig	ation 28e Place of Injury - At hom	fd 7:05 pm			-	used illic		
Divi	Certificati	Suicide 6 Could n 4 Homicide determi	ot be	idence		C1	or Town, State Learspr)12480 Har ing,Md.	al Route Number, City vey Rd.	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical C	Check only	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.							
HSHS	Æ	29b. Signature and title of certifier	1		29c. License numbe	er		9d, Date signed (Mon		
h		30. Name and address of person wh	no completed cause of death (Item 2:	(3a)	O.C.M.E.			anuary 19, 2012		
Ψ		Pamela E. Southall, MD	Assistant Medical Exam	niner 900 W. I	Baltimore Stre	et, Baltimo	re, MD 2122	23		
St Regis		31. Date filed (Month, Day Year)	32. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:25A. M January 18, 2012 Physician/ Nadine Jones W. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Examiner College Park 4707 Kiernan Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** March 31,1926 Days Min 1 🗆 M 2 💢 F 431-30-9501 85 Arkansas **Director** Jsual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4707 Kiernan Road 20740 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural" no 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White Specify. 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Homer Williams Eula Basham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay E. Hedge -daughter 10308 Balsamwood Drive Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/23/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald WorsBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any social to any cause. Enter Underlying Due to jor as a consequence of Exami the attending physician and thed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. Division of Vital Records, P.O. Box 68760 IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) after death.

Director: After this certificate has been signed by the atter in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 😾 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No Be 25. Was case referred to medical Hospital မ 1 Tes 2 XNo ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Funeral Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

within 2

(Check

only one) 29b. Signature and title

te filed (Month, Day, Year)
JAN 3 D 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Michelle Price, M.D. 11055 Little Patuxent Parkway Columbia, Maryland 21044

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D50778

29d. Date signed (Month, Day, Year, January 18, 2012

Please Type or Print in Black Indelible Ink Fragre All Copies Are Legible.

Amend 7,8,9 per FH G924 2/3/12 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 2012 Day Physician/ 1645 Bette L. Koehler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital
Social Security Number 6. Sex 7. Age (In yrs. <u>Berlin</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Funeral Country) Ohio Months 1 □ M 2 🗶 F 9/25/1945 66 Director 212-50-4935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rector Yes 2 No Ocean City MD Worcester ۵ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral <u> 21842</u> USA Unit 210 Polynesian 3rd Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 X Married ģ timore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. Speciwhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah VanWinkle Cherry Groome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Webb Road, Stewartstown, PA 17363 Julia Hildreth/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plate) LC 1 🗌 Burial 2 Cremation 3 🗆 Removal from State Denation 5 Other (Specify) Direct Cremation, 1-11-2012 Dover, DE 21 Signatur Bennie Ad Sin ferility 917 W. Isabella St. of Funeral Service Licens Funeral Home Salisbury, MD 21801 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ near a disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 4 ☐ Pregnami : 9 ☐ Unknown 9 Unknown Othersignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 3 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral Certificate: 1 Natural 5 Pending Division 24 hours after death. Funeral Director: Af Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed within 2 To the F only one) 29b. Signature and title of certifier 30. Mame and address of person who completed Then 31. Date filed (Month, Day, 32. Registrar's Signature State 11 2012 backs JAN Registrar

9/25/1945

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January Physician/ 12:16 KNIGHT LAURA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Dav. Year, 1 □ M 2 🏲 F **Director** 214-60-7021 June 6, 1923 Virginia 88 Usual Residence of Dece 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21703 United States 487 Hobnail Court permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker nt of Health and Mental Hyg t; If item 27 is marked othe or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Fannie Mae Payne Thomas Walter Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 986 Ridge Road, Mt. Airy, Maryland 21771 Charles Knight / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department o Important: If any injury or Stauffer Crematory Inc.1/11/2012 Frederick, Maryland. 4 Donation 5 Other (Specify) Name and Address of Facility
Stauffer Funeral Homes P. A
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of neral Service ion daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Approximate Interval Between Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Disease Atterscleratio Vascular Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA မှ 1 🗌 Yes 28a. Date of injury (Month, Day, Year) Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation s after death Il Director: A ed in by the f Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours aft To the Funeral Dir completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one)

3 State

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day,

10.N2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Tolino, M.D.

rederick

MD

32. Registrar's Signature

MOS1610

21702

29d. Date signed (Month. Day, Year)

12

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5	Funeral Director		427-26-3599	6. Sex 7. A	ige (In yrs. la	ast birthday) Yrs.	Month:	ler 1 Year s Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da DEC 17		922 g. B	irthplac ountry,		or Foreign BAMA	
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77	th with ms 23 must	Funeral	PERRY POINT VA			La		2190					T	O STATES			
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Maryland	tal Hy ed oth	To Be	17. Father's Name (First, Middle, Le HENRY KOONCE							ner's Name		Maidei	aiden Surname)				
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	and 2 s Health tem 27	l,	GREGORY KOONCE	/ SON					ON, S	AN AN	TONIO,	TE	XAS 782	53			
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		te c	Place of Dispo emetery, cren LINGTO	natory`or	other place			ate UNK		Location - City o			NIA	
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Box 68760	eath ce attend d for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant	2 Feta at time of c	ıl death 3	Ectopio Other (у				23d. Date of d Month	elivery Da		Year	
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<u>a</u>	ian: T	Be C	25. Was case referred to medical examiner?					26. Pla	ace of Dea	ath (Check	1 \(\superset \text{Yes}\)	2 (4)	No 1 🗆 Y	es z	□ NO		
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on of	Attending Physician: The law requires that the death certificate be exit death. sctor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buria	Certificate:	27. Manner of Death 1 Manner of Death 5 Pending 2 Accident Investigs		jury lay, Year)	28b. Time of injury	М	28c. Injury work' 1 🗆	at ? Yes 2 🗆	-	28d. Describe how injury occurred						
Division of Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	28e. Place of In	ijury - At ho tc. (Specify	me, farm, stre	eet, facto	ory, office		2	8f. Location (\$ City or Tov		nd Number or R e)	ural Ro	oute Numb	er,	
_	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Medical	(Check 2 Medical Ex	Physician: To the best c	examination	and/or invest	tigation, in	n my opinio	n, death o	occurred at t	he time, date a	and plac	e, and due to the	cause		nner stated.	
	To the within To the Compl	Σ	only one) 3 \sqcup Certifying 1 29b. Signature and title of certifier	Nurse Practioner: To th	e best of my	r knowledge, d		orred at the Oc. License		e and place	, and due to th		ate signed (Mon				
			I /m /	2				D53	739	9		31	HUARY	14	1,20	12	
,	HIVA		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type, P	Print)	UTH NO	ARF S	45 TEA	1 PER	24 (Point N	10	2190	1	
	Stat Registra		Suresh Shand 31. Date filed (Month, Day, Year) JAN 18	2012 32. Regist	trar's Signat	d. A	ark	ب	<u>,</u>		1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} 8:10 Louis Kennedy January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3112 Gracefield Road. Silver Spring Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Min Hours 578-18-4868 1 X M 2 - F Director 89 Dec. 26, 1922 Washington, DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d Inside City Limits Oa. State 10c. City, Town or Location Director MD Silver Spring Montgomery 1 🗌 Yes 2 🎦 No the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3112 Gracefield Road, #209 20904 USA death or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Examiner Armed Forces Black White, etc. 1 Never Married 2X Married þ XYes 2 Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White WWII other than "natural", ent, the Medical Exar 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 DC Fire Dept. Lieutenant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ပ Frank A. Kennedy Minnie Mae Torbert and ∿ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patrick E. Kennedy/Son 1038 Carnation Drive, Rockville, MD 1 and 2 s of Health item 27 other! 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 Important: If it any injury or o once. Ebenezer United 1 Burial 2 Cremation 3 Removal from State Jan. 4 Donation 5 Other (Specify) 2012 Oldham, Virginia Methodist Church Cemetery FrancTs do Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 Signature of Funeral Service Licens Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metaststic Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a 60 soudenes on B that initiated events resulting in death) Last and Due to (or as a consequence of) as the buria signed by the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: . nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons this certificate has perform 1 Yes 2 No Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined City or Town, State)

10+1

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

only one

29b. Signature and title of certifier

Andrew Kundrat, MD

JAN 1 1 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D36716

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

se of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904

29d. Date signed (Month, Day, Year)

Jan. 10, 2012

Mocman Elinore

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			For State Registrar	Otato or mary.		ertificat				,	Reg. No	20	12	02168
	Dhusisis	.,	1. Decedent's Name (First, Middle, Last)						2.	Date of De	eath _ Da	v - \	ear	3. Time of Death
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	or 28		ID Worces 10e. Street and Number	ter	Berl	10f. Zip	o Code				10g. Cit	tizen of Wh	at Count	try?
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Ö	atural	etec	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates.	16a, De	cedent's Usu	al Occupa	ation	-		16b. K	Specify: (ind of Bus	whi ness Ind	
Baltimore, Maryland 21215-0036	within 72 h giene. ier than "ni the Medi;	Completed	(Specify only highest grade Elementary/Seconday (0-12) 1.2	(Gi	(Give kind of work done during most of working life. DO NOT use retired) Technical Writer						IUS Navv			
pu	be filed v ental Hyg ked othe ic event,	Ве	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden											
Уlа	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	John Hughes		_				iett					
Σa		7/4	19a. Informant's Name/Relationship (Type Carl Kocman, I		140	ailing Addres Coas	,							ode)
re,			20a. Method of Disposition	20	b. Place of Di	sposition (Na	me of	-1	Date	9	20c. L	ocation - C		wn, State
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	hydician/		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1	EWI								Interval Between Onset and Death
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Il Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)								or Rural	Route Number,		
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	To the within To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of	or my knowled		c. License		and place,	and due to t		ate signed		
			Mahnel	nis) 6	051	5		_ //	8/12		
0	1 10		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Typ		56-0	C D	2,5	4/10	7610	V 4	111	2/804
J	リロ Sta	te_	31. Date filed (Month, Day, Year)	32. Regintrar's Si	ignature	~ V	17014	EVI	-/ X	(UD)	>0~	/_/	-10	447
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{14}$, Month January 2012 Lucille Agnes Kimball 3:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2503 Woodberry Street Prince George's Hyattsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 X F Months Days Hours Min July 2 **Director** 94 1917 Cleveland, 217-46-9505 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George's Hyattsville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Heath and Mertal Hyglend and art. If item 27 is marked other than "natural", or items 23a ant. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must bury or other traumatic event, the Medical Examiner must but a context that the Medical Examiner must but a context that the Medical Examiner must but a context that the Medical Examiner must but a context that the medical Examiner must but a context that the medical Examiner must be a context to the context that the medical Examiner must be a context to the context that 2503 Woodberry Street 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🛣 No 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Adolph Sadler Celia Agnes Ruppelt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Kimball / Son 10619 Summer Oak Drive, Burke, VA 22015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 1/19/2012 Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Spiss My Regers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Congestive Heart Failure Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months? Dav Year ☐ Pregnant at time of death ☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina 2 Accident
3 Suicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29d. Date signed (Month, Day, Year) D45660 January 16, 2012 ddress of person who completed cause of death m 23a) (Type, Print) Dpinder Singh, 14300 Gallant Fox Lane, Suite 124, Bowie, MD 20715

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fb 938 4-4-13 vt amend items 7.8 per fb g938 4-12-13 vt

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month a M Pauline Killebrew January 8 9:26 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5903 Rosedale Drive Prince George's Hvattsville Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 22 If Under 1 Year | If Under 24 Hrs. 1927 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Days Hours New York **Director** 84 060-20-2408 Ju<u>ne</u> Usual Residence of Decedent 28a-f shov items 23a or 28a-1 snoner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5903 Rosedale Drive 20782 United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after 10 bepartment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or any injury or other traumasis. ģ 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: h: African <u>America</u>n If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) White House Telecommunications Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Eulalie Shinery 2 Randolph Gerard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeneen Gibbs - GrandDaughter 1536 Lexington Avenue #10F New York, NY 10029 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20, cemetery, crematory or other place) Quantico 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Triangle, Virginia Cemetery Signature of Funeral Service Live 22. Name and Address of Facility Stewart Funeral Home, Inc. to lun VIR 4001 Benning Road NE Washington, DC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hyperlipidemia Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3
 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown g Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Failure To Thrive Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate | 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 😿 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work Accident nours after death neral Director: A I filled in by the fi 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0058290 January 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Muttath 5711 Sarvis Avenue, Suite 200 Riverdale, Md.

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:31 A M Ronald L. Kemp, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury WICOMICO Coastal . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 1 ★ M 2 □ F Maryland Hours 220-32-8404 Director 75 1936 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10c. City, Town or Location Director 10d, Inside City Limits Rhodesdale MD Dorchester 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21659 6236 Fooks Mill Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ō Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 Yes 2 No Specify: White "natural" 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Bakery 7 Plant Operations Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t be t ပ္ Alfred Kemp Molly Williamson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. Kemp, Jr./ Son 6236 Fooks Mill Rd., Rhodesdale, MD Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Eastern Sh. Veterans Cem. 01/20/12 Hurlock, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22, Name and Address of Facility Framptom Funeral Home, Wichail 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition _ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events signed by the attending physician and d be detached for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 4 Pregnant : 9 Unknown in the past 12 months? Year Day Pregnant at time of death 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director. After this certificate to completed filled in by the funeral director, page 2 No Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred V Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 82. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Minnie P. King 2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Peath HICOMICO Kegional SA LISB414 Funeral Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 220-26-2246 1 M 2 XF 10-16-1929 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1X Yes 2 ☐ No MD Wicomico Salisbury 0 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 105 TimesSquare 21801 USA ral", or items? and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian, Black, White, etc. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give SpedBlack 3 XWidowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Line Worker Campbell Soup Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Joseph M. Turner Savvanah Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pierce/Sister 3522 Payne Rd, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-11-2012 Pocomoke, MD Sinai Cem Bennie ad Askis & Facility 17 W. Isabella St. Signatur of Funeral Service Licenses uneral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician AD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCV Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : has certificate ! performed 1 ☐ Yes 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident 🗌 Funeral Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert and address of person who completed cause of death (Item 23a) (Type, Print) CORROLL ST. 100 E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan 21 [.]2012 10:31 AM Kipe Louise Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany 13707 Uhl Highway Oldtown Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. Date of Birth Funeral Months 1 🗆 M 2 🖵 F Days Hours Min. **Director** Jul 26 <u>218-30-0145</u> 28a-f shov 10a. State 10b. County items 23a or 200 iner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Allegany Oldtown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13707 Uhl Highway 21555 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No 1 XNever Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates Specify. "natural" 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dental Assistant Dentistry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မှ Page 1 and 2 should be Frances T. Bartik Wesley James Kipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cot 13212 Blank Rd. NW Mt. Savage M Department of Health ar Important: If item 27 is any injury or other trau William Kipe MD 21545 son Baltimore, 20a. Method of Disposition / Place of Disposition (Name of cemetery, crematory or other place)
 St. Mary's Cemetery Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 1/25/2013 MD Cumberland Conation 5 Other (Specify) Signatur 22. Name and Address of Facility
Scarpelli Funeral Home, PA of Funéral Ser e Licensee 108 Virginia Avenue: Cumberland, MD 21502 ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Pregnant at time of death Month 9 🗌 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 🗆 Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after deatl To the Funeral Director: completed filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifi 29c. License number 29d Date signed (Month, Day, Year) 0915 23 who completed cause of death (Item 23a) (Type, Print) Street Cumberland, MD 21502 124 W. Third WI

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANDINI 2/11 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel AAMC Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗸 F 95 1/28/1916 Country) 151-03-9174 Director NJ Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes XX No **Gambrills** Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral traumatic event, the Medical Examiner must 21054 USA 1688 Preakness Drive "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black White etc þ 1 Never Married 2 Married Yes 2xxNo Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give 3 XXWidowed 4 ☐ Divorced Specify. Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Parish Rectory Bookkeeper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Teresa Mastrogiovanni Gabriel Giuliano permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Teresa Taylor</u> 1688 Preakness Dr. Gambrills, MD 21054 daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Totowa, NJ 1/9/2012 Laurel Grove Memorial 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. any Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer e and Death Immediate Cause (Final disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? After 1-1 Natural 5 \square Pending s after death. 1 Yes 2 🗆 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. only one Certifying Nurse Practiseer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of cert ompleted cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carla Μ. Logan 2012 January 07 3:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 406 Buckspur Court Millersville Anne Arundel If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 63 **Director** 222-32-4755 1 M 2 X F Delaware Mar.11,1948 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Buckspur Court 21108 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: and Mental Hygiene. Is marked other than "natural", 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Constellation Energy Env. Manager 5+ Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Richard C. Moutz Edwina Stayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Buckspur Court Millersville, MD 21108 Ray Lewis / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Jan. Baltimore, MD Metro Crematory, INC. 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral H.
495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licenses Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final varian cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 1 🗌 Yes 2 🗎 No Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Funeral Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Medical Parkway

Annapolis, Md.

Selonick, mo

1 0 2012

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Midd.	lle / act)		Cer	tificate of D	eath	2. Date of Dea	Reg. N	<u>· 20 </u>	$\frac{2}{100}$		
	Physicia			arl Lewis					Janua Janua	1rv	^{ay} 10, 201	3. Time of Death 2 5:54 A M		
	Medic Examin		4a. Facility Name (if not institution	on, give street and number)	. ,		4b. City, Town, or	Location of Deat			c. County of Dea	th		
J.				gional Hos				ure/			Prince	George's		
	Funeral Director		5. Social Security Number 231-40-8608	6. Sex 7. Ag	ge (In yrs. lasi 76	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year) 193	9. Bir	rthplace (State or Foreign ountry) VA		
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	у	10c. City.	Town or Loc	ation					10d. Inside City Limits		
	larylar 3a-f sl ified	ectc	MD Princ	e George's	el						1 Yes 2 □ No			
	the N	- Dir	10e. Street and Number			10f. Zip Code					itizen of What Co	ountry?		
	h with	Funeral Director	7700 Cherry La	ne, Apt.#114			20707			US				
020	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	Armed Forces? √Aarried 2 ☐ Married			Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit			
212-0036	72 hour	Completed	15. Decedi (Specify only high	ent's Education hest grade completed)		(Give k	ent's Usual Occupa ind of work done do NOT use retired)		orking	16b.	16b. Kind of Business Industry			
7	within giene. er tha		Elementary/Seconday (0-12) 12th	College (1-4 or	5+)		stic Engi	ineer		Private				
yland	tal Hy d oth event	To Be	17. Father's Name (First, Middle,			18. Mother's Name (First, Mid-					,			
<u> </u>	uld be I Men narke natic	-	Charlie Harri		- 7				et Kizzi					
, Mai	nd 2 sho ealth and n 27 is i		19a. Informant's Name/Relations Renee' Lewis /		. 0		g Address (Street a					pring,MD2091		
saltimore,	ye 1 ar t of He If iter or oth	- 1	20a. Method of Disposition 1 Disposition 1 Cremation	n 3 🗌 Removal from State	cer	metery, crem	sition (Name of atory or other place		Date		Location - City or			
	it. Pag rtmen rtant: njury		4 Donation 5 Other	(Specify)	Arli		Cemetery Name and Address		-2012		rlington			
מ	perm Depa Impo any i		21. Signature of Funeral Service	5 Mar			5538 Mar							
				or complications that cause t only one cause on each lin		Do not ente	r the mode of dying	, such as cardia	c or respiratory an	rest,		Approximate Interval Between		
~]	Medicai	. 4	Immediate Cause (Final disease or condition resulting in death)				lar Acc	cident				Onset and Death		
	Examiner		Date of the control o	Due to (or as	1 -1	nce ot):	c							
	ALC: U	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque		1							
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Conge			rt Faile	ire						
_	oe exe ician a ourial-	alE	resulting in death) Last	Due to (or as	a conseque	nce ot):								
9	cate by physical care by the by the by	ledical		d										
DOX 00/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown	al death 3 🔲 Ectopic pregnancy					23d. Date of delivery Month Day Year				
	hat the	by Ph	Part II. Other significant condit	tions contributing to death I	but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco	use contribute t	o the cause of death?		
J.S.	uires l	ed b							1 🗆	Yes 2	2 □ No 3 □ F	Probably 4 X Unknown		
Vital Records,	The law req tte has bee page 2 sho	Completed							24a. Was auto perfo 1 \(\sum \text{Yes}	psy ormed?	prior to death?	utopsy findings available completion of cause of		
<u>a</u>	cian: ertifica ector, p	Be (25. Was case referred to medica examiner?	Hospital:				ce of Death (Ch						
>	Physi this c	 10	1 Yes 2 No 27. Manner of Death	1 XInpat 28a. Date of inju	tient 2 E	R/Outpatien	t 3 DOA Othe	4 LI Nursing	Home 5 Resid			cify)		
0	ding th. After funer	cate	1 X Natural 5 ☐ Pend			injury	work's	Yes 2 No	28d. Describe h	iow inju	ary occurred			
DIVISION OF	or Atter after dea Director in by the	Certificate:	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place of Inj	jury - At hom tc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tov			ural Route Number,		
ב	Hospital 24 hours : Funeral I	Medical	(Check 2 Medical	ng Physician: To the best of Examiner: On the basis of	examination a	and/or invest	igation, in my opinio	n, death occurred	d at the time, date a	and plac	ce, and due to the	cause(s) and manner stated		
	To the within To the compl	Σ	only one) 3 L Certifyir 29b. Signature and title of certifi	ng Nurse Practioner: To the)	Mowledge, C	29c. License	number	nace, and ade to th		tate signed (Mon			
	П		y sau	itue, M) 	20-1 ~ -		0093	720-11:	1/1	10/20	12		
)	- /			ntla, MD 1	Laure	1 Reg	ional Hosp	pital 1	1300 Var Laurel,	M		00dd 0707		
	Stat Registra		31. Date filed (Month, Day, Year)	Senera 32. Registr	rar's Signatu	re was								
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2012 Year 10:31 PM Physician/ Lutz Kathie Lee January Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Somerset Marion Station 5870 Cornstack Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** 218-58-7045 Director 1 M 2 X F 59 01/15/1952 California 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State notified at Director 1 Ves 2 V No Marion Station Somerset Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Examiner must be Funeral USA items 23a 21838 5870 Cornstack Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. should be filed within 72 hours after on and Mental Hygiene. <u>\$</u> 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify Specify: Ves Give White 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 5870 Cornstack Rd., Marion Station, MD 21838 Brian Irwin/spouse Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Important: It any njury or Salisbury, MD Salisbury Crematory 1/10/2012 4 Denation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FFMALE JSe : 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 morths?

1 Yes 2 No

9 Unknown Month Year Day Pregnant at time of death 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director, After this certificate has b prior to completion of cause of death? performe Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Mann of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR, SAUSBURY MP21884

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#31see#32; 1/11/12; BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Day 06 2012 Physician/ atin 1:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner National Institutes of Health Montagmeri 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Y9^t/7*02**/1966 557-69-7179 45 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If leng 71 is marked other than "natural" ---any injury or other trans------------10a. State 10d. Inside City Limits 10c. City. Town or Location Director Fair Oaks 1 Yes 2 X No CA Sacramento 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 95628 U.S.A. 7711 Juan Way, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? δ 1 X Never Married 2 Married 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Law Law Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Nancy Esther Colon Edward Latin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19019 Ravenswood Court, Morgan Hill, California95037 Jay Latin - Brother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 01/11/2012 | Sacramento, California 4 ☐ Donation 5 ☐ Other (Specify) Home of Peace Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens ynonateral MO 1524 11800 New Hampshire Ave., SilverSpring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAD Physician/ 162012 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed 42MBN 1799C Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 L retai usa.
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate P.

Completed filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 No 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Tes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Center

Betheria Maryland 20892

FERRIST

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2012 EARLE S. LOCKWOOD, 9:30 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 172 Center St. Apt. 6 A Cecilton Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Maryland **Director** 219-14-2395 90 17 1921 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 172 Center St. U.S.A. Apt. 6 A 21913 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7 Painter Self-employed Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Farher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earle S. Lockwood, Sr. Hilda King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon McClain (daughter) 1010 White Birch Dr. Newark, DE. 19713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cemetery 1/25/12 Cecilton, MD. Signature of Funeral Service Licensee 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 23a Part . Enter the disease, or complications triat cause shock, or feart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ coronary Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy perform the funeral director, page The this certificate 2 N Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 🗌 Yes 2 🗎 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State Registrar

only one)

29b. Signature and title of certifie

W. Bruce Obenshain,

31. Date filed (Month, Day, Year)
JAN 3 0 2012 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

251 S. Bohemia Ave. Cecilton, MD. 21913

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Helen 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Washinaton Hagerstown are 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Months Hours 217-16-2434 89 **Director** 1 □ M 2 🗓 F 23,1922 July Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Washington MD Hagerstown 1 XYes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 534 G Pangborn Blvd. 21740 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceuent 2.2 Armed Forces? 1 Yes 2 No þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 XWidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 Financial Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McKinley Sarah Wastler other traumatic ige 1 and 2 should be nt of Health and Men t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Landis (Son) 534 G Pangborn Blvd., Hagerstown. MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crem. 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2012 Smithsburg. MD 21. Signature of Funeral Service Licensee Keeney & Bastord P.A. Funeral 106 E. Church St., Frederick, MO1612 Leccien Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Ph i i n/ Atheroselerotic colin voscultur L disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine convestive Heart Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Fibrillat The law requires that the death certificate be Atrial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Lascer, Vascular Dementia, Major 1 Yes 2 No 3 Probably 4 Unknown Completed Depression, Anxiety, Osteoarthritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 19/12

State

Registrar

Date filed (Month, Day,

JAN 26

Stucker-333 Mill Street, Howerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend I tem 3 per med cert 6924 2/21/12 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 01 2012 11:30 AM Beatrice Mae McMullen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospita 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 3/3/1909 Hours Min 1 🗌 M 2 🕱 F Director 102 PA 218-32-8291 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Ceci1 Rising Sun MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 23a Funeral USA 2 Meadow Court 21911 items death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Clyde G. Pyle Nancy Louise Starr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel McMullen - son Telegraph Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Brookview Cemetery 01/14/2012 Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si per e of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen St. Rising Sun, MD 21911 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ neumours disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical certificate be of Vital Records, P.O. Box 68760 the IF FEMALE: yes, outcome of pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown lor Day Month Year Pregnant at time of death the cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ funeral 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 - Pending Division М Investigation Accident completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Hospital Medical 1,💥 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) D0062190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHATINAWAZ KHW AUGUSTINE HERMAN HWY SUITEA, CHESAPEAKE CITY, MD 21915 2533

State

Registrar

31. Date filed (Month, Day, Year)

JAN 13

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 7, 2012 Year Edward Augustine McCoy 6:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8402 Curiosity Court Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 3075-241×11506 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**₩** M 2 □ F May 20, 1928 272 32 1506 83 **Director** Kentucky Usual Residence of Decedent 28a-f shov 10a. State or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick Walkersville ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8402 Curiosity Court 21793 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedon...
Armed Forces?
1 瑟 Yes 2 □ No Korean
Was Give War Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Marketing & Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward McCov Barbara Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret J. McCoy / Wife 8402 Curiosity Ct., Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of Jan. Day 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2012 Frederick, Maryland 4 Donation 5 Other (Specify) Resthaven Crematory 21. Signature of Juneral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Ca e (Final disease or condition MULTIPLE MYESOMA Physician/ 2 yEARS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examiner Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC PENAL of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 🔽 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of I or Attending F safter death. I Director: After 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3, cause of death (Item 23a) (Type, Print) CONNER MO SEIN SEVENTH ST. FREDERICK MD 21701

State

Registrar
DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01-05-2012 Kenneth Rodney Meals 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot William Hill Manor Easton If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 X M 2 D F 10-21-1925 86 MD **Director** 213-20-7241 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 21601 USA 501 Dutchman's Lane filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married <u></u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Printing Company 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Raymond E. Meals Mary C. Schwenk or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Patricia Meals Mason (Daughter) 6820 Thonotosassa Rd Plant City, FL 33565 20a. Method of Disposition 20b. Place of Disposition (Name of Chesapeake Cremation 1-6-2012 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stevensville, MD 21. Sign We of F Pellows, Helienbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final METASTATIC Say Auro Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DEMENTIA 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death. • Funeral Director: After this certificate has b tor: After this certificate has the funeral director, page 2 s autopsy perform 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) _ 2 💢 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🔲 No injury 1 Natural 5 Pending 2 Accider
3 Suicide Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8+IVA RS

within 2

State Registrar

completed

(Check

only one 29b. Signature

321 BLOOMINGDALE AVE FEDRALSBI

JAN 0 9 2012 back

death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O/ Physician/ Charles 0050 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Annes Emergency (ente Vueenstown Queen Anne Date of Birth 9. Birthplace (State or Foreign **Funeral** 32 1**X** M 2 □ F Months Hours Min. (Month, Day, Ye 01 **Director** 22 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 √ Yes 2 ☐ No MD Oueen Anne Oueenstown 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 642 DelRose Avenue 21658 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Farmhand <u>Farming</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Henry Miller Lillie Louise Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kingsbridge DR Burlington, NJ 08016 Rosalee Butler 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Chesterfield 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/7/2012 Centreville, MD 4 Donation 5 Other (Specify) 21. Sign there of Funeral Service Licens 22. Name and Address of Facility Bennie Smith Funeral Home <u>855 High</u> STChestertown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Schowe disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) anding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 this certificate 2 No 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ည 1 🗌 Yes 2 3 No 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funera injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death opening at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month. Day, Year) 3

P7 5

State Registrar Conquer.

M

2540

32. Registrar's Signature

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

L. VILETS

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Amend Item 2 Registrar	5 per me,g924,02/15/	72012dhb tificate of Death	vientai mygie _{Reg.}	No. 2012 02186				
	Physicia		1. Decedent's Name (First, Middle, Las	mc Donald		2. Date of Death Month	Day Year /806 P M				
- Single	Medic Examin		4a. Facility Name (if not institution, give	street and nymber)	4b. City, Town, or Location of Death		4c. County of Death **MICOMICO** **TOTAL COMMITTEE TO THE PROPERTY OF THE PR				
	Funeral Director		5. Social Security Number 6. Se 6. Security Number 6. Security Number 128 - 9768 12	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)				
	and show 1 at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	3-11-	10d. Inside City Limits				
	Maryl 28a-f notified	Director	Va. Accor	nack Green	backville		1 ♣Yes 2 ☐ No				
	with the 23a or 1st be r	Funeral D	10e. Street and Number 3 7 / 05 / 10 e.	entire Cour	10f. Zip Code 2335-6	10g	Citizen of What Country?				
5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show tedical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- pecify Yes or No- No- No- No- No- No- No- No- No- No-	14. Race - American Indian, Black, White, etc. Specify: White				
21215-0	thin 7, ane. than he Me	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired)	king 16	b. Kind of Business/Industry Police Dapt				
	ould be filed within d Mental Hygiene. marked other tha matic event, the N	To Be	17. Father's Name (First, Middle, Last)	Maponald	18. Mother's Nan	ne (First, Middle, Maid	den Surname) Bounty McDonald				
Maryland	shou hand 7 is rr traum		19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or Rul		7				
altimore,	Page 1 and 2 strent of Health ant: If item 27 ary or other truin		20a. Method of Disposition 1	nemoval nom state	natory or other place)	Date 20	C. Location - City or Town, State 23356				
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licens		2. Name and Address of Facility alyer Funeral Ho	mc 6327	Church ST 23836				
je poka .	Physician/		shock, or heart failure. List only or Immediate Cause (Final disease or condition	olications that caused the death. Do not entrine cause on each line. Intra cereb	er the mode of dying, such as cardiace nal hemov		Approximate Interval Between Onset and Death Nouv				
THE ST	Medical Examiner		resulting in death)	Due to (or as a consequence of):		l					
	d ansit	Examiner	Sequentially list conditions, if any, loading to in module cause. Enter Underlying Cause (Disease or injury that initiated events	Clue to (or se a corresquence of)	Jule	WAMINER					
0	cate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequence of): d	THE THE PART OF TH	ON APPROVED BY MEE	ICAT FLOW				
68760	0 2 0		IF FEMALE:	23c. If yes, outcome of pregnancy	CELY						
Вох	ne death certifica y the attending ph iched for use as t	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
ds, P.O	requires that the dea been signed by the a should be detached t	by	Part II. Other significant conditions co	ontributing to death but not resulting in the u	underlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 \(\text{No} \) No 3 \(\text{Probably} \) Probably 4 \(\text{M} \) Unknown				
Reco	The law ate has page 2	Completed				24a. Was an autopsy performe					
of Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:	26. Place of Death (Che		o 6 Other (Specify)				
on of \	Attending Physician: If death. ector: After this certific by the funeral director,	Certificate: T	27. Manner of Death 1 Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	1 A Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28d. Describe how injury occurred							
>	i Sir o		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, tate)				
	e Hospital of 24 hours a e Funeral Dietely filled	Medical	(Check 2 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or invest se Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred	at the time, date and p	place, and due to the cause(s) and manner stated.				
	To the within 2 To the comple	_	9b. Signature and little of certifier	144	29c. License number	29d	. Date signed (Month, Day, Year)				
	1570		30. Name and address of person who co	completed cause of death (Item 23a) (Type, I	Print MT. VELKON RO	Princess	Anne, ms				
	Sta Registra		31. Date filed (Month Pay Year 2 20	12 32 Registrar's Signature	arles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 James Michael Moore 8:32 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 XM 2 - F 7/2/1944 Director 216-42-1266 67 MD Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9816 Elm St. 21842 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white 3 Divorced Specify: Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Construction event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F t. Page 1 and 2 should be file thrent of Health and Mental rtant: If item 27 is marked or 27 is marked c traumatic eve ည James I. Moore Margaret Kidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10171 Woodbury Dr., Wexford, PA 15090 Allyson M. Minton/daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 1/10/12 First Millsboro, DE 21. Signature of Mineral Service Lices 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Food Bolas Medical resulting in death) Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trait si Morbid Obesity that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2X No 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 8:00 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide 1612 Chokina Investigation M 6 Could not be Place of Injury building, etc. (Specin), Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 9816 EIMSL OC, IMD Medical Certifying Physician: To thi balt of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practione : To t... best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 150497 29b. Signature and title of certifie: 19/2012 VIR6INIA-010124318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 021851 MAHENDRASINH 101 Market St. MO 2A15+1 JADE ocomoke 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#25.PerMEOPGC1-13-12cr Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Voor 2252 M Physician/ 2012 Keith, M.les Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltime of planyland Medal & 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 11-7-1970 North Carolina 243-33-7361 **Director №** м 2 🗆 ғ 41 Usual Residence of Dec ms 23a or 28a-f show must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County the Maryland Director Greenbelt PG MD 1

Yes 2 □ No 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA items 23a 20770 7801 Mandan Rd. #203 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceden.
Armed Forces?
Ves 2 X No 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Black, White, etc ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Ups Driver Be traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Miles ပ Darnell Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7801 Mandan Rd. #203 Greenbelt, MD 20770 19a. Informant's Name/Relationship (Type, Print) of Health a Vanita Miles/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Providence Ch. Cemetery 1-14- 2012 Yanceyville, NC 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicalan Re renten disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) -trar and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Unknown 2 No After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1
Yes 2 No 24a. Was an performed' within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d, Date signed (Month, Day, Year) 29b. Signature MPI 1003041997 mpleted cause of death (Item 23a) (Type, Print) Battimane MD 21201

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÄNÜARY 21, 2012 CHARLES OLIVER MESSER 7:20 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 125 4th St. Oueen Anne's Crumpton 8. Date of Birth (Month, Day, June 21 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min 1 X M 2 D F 245-55-3270 1935 North Carolina Director 76 Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Oueen Anne's Crumpton 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 125 4th St. 21628 U.S.A. death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No 1958 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 K Married þ hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed -1961Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) Gun & Knife Dealer Self-employed should be filed within and Mental Hygien, 7 is marked other th 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Warren H. Messer Lela Bullman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (wife) Carolyn S. Messer Box 88 Crumpton, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Western Carolina State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1/27/12 Black Mountain, NC. Cemetery.

22. Name and Ad less of Facility
Calena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 no vi suneral Service I 21. Sig M00510 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in eath) Malignat para Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of). burialphysicians the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown by signed b Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) _2 🔽 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63 2012 23 en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Ukens, 2540 Centreville Rd. Centreville, MD. M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2012

DHMH 17 Rev 7/2009

Registrar

B. Sparker

Jeffrey	Mich	nael	Myers	
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- Company	_	Strange			- 8	

		1- For State Certific Registrar	cate of Death	Reg. No.						
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death						
Medical Exam	iner	Jeffery Michael Myers		Month Day Year 1525 hrs						
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
		Meritus Medical Center	Hagerstown	Washington						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to	oirthday) If Under 1 Year If Under 24Hrs							
Director		217-82-5516 ₁ ⊠ _{M 2} _{□ F} 39	Yrs. Months Days Hours Min	May 8, 1972 Foreign CountryMaryland						
		Usual Residence of Decedent	113.	riay 0, 1972						
kus			vn or Location	10d. Inside City Limits						
		Maryland Washington Co. Hager	cstown	1 X Yes 2 No						
Aaryland 28a-f show 1 at once.	ğ	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
Mar r 28	Director									
h the 23g o		1324 Potomac Avenue Apt. 21	21742	U.S.A,						
h wii	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 							
deat or its	Ë	1 Yes 2 No								
after incr	ρ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	specify: White						
ours hatur xam	Þ	15. Decedent's Education (Specify only highest grade completed) 16	 Decedent's Usual Occupation (Give kind of volume of working life, DO NOT use retired.) 							
6 72 h	Completed	Elementery/Secondary (0-12) College (1-4 or 5+)								
Arthin Ga	ᇤ	12	Forklift Operator	Ribbon Mfg.						
5-0 led v	ပိ		18.Mother's Name	e (First, Middle, Maiden Surname)						
21 be fi ntal	Be	Ronald Myers	Betty Po	oindexter						
ould de Me	70			Rural Route Number, City or Town, State, Zip Code)						
MD 12 st th an 127 i		Amy R. Myers/ Wife 1 20a. Method of Disposition 20b. Plac	.324 Potomac Ave. Apt	-21 Hagerstown, MD 21742 Date 20c. Location - City or Town, State						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Plac	e of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State						
DO ages at of the other		1 X Burial 2 Cremation 3 Removal from State Res t	atory or other place) Haven Cemetery Jan	.20,2012 Hagerstown, Maryland						
it. Purtine artine ortar		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		ıglas A. Fiery Funeral Home						
Dependent in in in in in in in in in in in in in		2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	1331 Factorn Plyd	N Harrist MD 017/0						
Physician	_	23a. Part I. Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
/Medical		failure. List only one cause on each line.		Between Onset end						
Examiner			cication complicated	by drowning Death						
		but to (or as a consequence or).								
	9	Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of):	·							
	mine	cause. Enter Underlying Cause (Disease or injury that initiated								
=	Exar	events resulting in death) Last Due to (or as a consequence of):								
ecuted and - transit		d.								
760, cate be execut physician and he burial - tra	/Medical	Manuel 23a,27,28a-1,per me,g924 2-8-12 sm								
760, ficate be ex g physician t the burial	₹ e	IF FEMALE: 23c. If yes, outcome of pregnance		23d. Date of delivery						
68 ertifi e as t	an		2 Fetal death 3 Ectopic pregna	ncy Month Day Year						
Box 687 e death certific the attending ed for use as the	Sic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)							
he de heed f	Physiciar	Part II. Other significant conditions contributing to death but not result	in the anded in	23e. Did tobacco use contribute to the cause of death?						
P.O.	à	reach. Outer significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 V Unknown						
uires n sign										
Records, The law require	Completed			24a. Was an 24b. Were autopsy findings available prior to completion of cause of						
Reco The law icate has	Ĕ			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
tal Re ian: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check							
Vital hysician: this certi	8	examiner? [Hospital:	72	g Home 5 Residence 6 Other:						
n of V ling Phy After th	은	1 7 163 2 103	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred						
of of of oding P. h.: After e funera	5	1 Natural (Month, Day, Year)		unknown						
ivisio	g	2 Accident Investigation 280 Place of Injury At home	farm, street, factory, office building, etc.	2001 1						
Division tal or Attendi	틥	Suicide Could not be		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1324 Potomac Ave. #21						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. transitions and increase the burial.	The state of beautier of beautiers of beauti									
in 24 he Fu detely	edical	(Check only	•							
To the vithing To the comp	ē	one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Ž	29b. Signature énd title of certifier	29c, License number	29d. Date signed (Month, Day, Year)						
1		all MM1/1	O.C.M.E.	January 17, 2012						
	ľ	30. Name and address of person who completed cause of death (Item 23a	-							
7		Zabiullah Ali, M.D. Assistant Medical Examiner 9	00 W. Baltimore Street, Baltimore,	MD 21223						
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Regist	_									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jan 19, .[□]2<u>012</u> Physician/ 4:20 AMM Musso Dr. Rocco Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (if not institution, give street and number) Allegany LaVale 11 Roger Way 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 🗆 F Months Mav **Director** 206-26-5056 ems 23a or 28a-f show r must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director LaVale 1 XYes 2 No MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with USA 21502 11 Roger Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or ite Armed Forces? 1 ☐ Yes 2 🗖 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Yes, Give white 3 Widowed 4 Divorced Year or Dates other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ABL Chemist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ Marie Rocco Charles Musso traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. MD 21502 11 Roger Way LaVale Joanne Musso wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify) 1/23/2012 MD SS Peter & Paul Cemetery Cumberland 22. Name and Address of Facility Scarpelli Funeral Home, PA Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause, each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Undarying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2: performed 2 🗆 No 2 - No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Matural Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Countrying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature person who completed cause of death (Item 23a) (Type, Print) 6 (Las Kent Ave. Ste. 309 Cumberland, MD 21502

Registrar

State

JAN 26

32, Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Physician/ 01 – 2012 15:32 PM Georgia Ann Nelson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral Director** 578-94-7624 1 □ M 2 💢 F 40 10-21-1971 DC Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director 1 X Yes 2 □ No MD Prince George's Suitland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US 20746 4309 Allies Road permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Yes. Give 3 Widowed 4 Divorced **Black** Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the Private Home Health Care Provider 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Melvis Price James Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 9906 Rosaryville Road, Upper Marlboro, MD 20772 <u>James Christian/Brother</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-23-2012 Harmony Memorial Landover, Md 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure-List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute curunary Medical resulting in death) Due to (or as a consequence of) Examiner pertensia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed Diabela malliath burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ξ in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) Yes 2 No the a detached 9 Unknown g 🕠 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1 Yes No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 2012 150689

State Registrar

DHMH 17 Rev 06-2011

Road chinton

SUMBAYA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK MANATIMA.

SHWAHE

32. Registrar's Signature

7503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For S' State Registrar	tate of Maryland		rtment of H tificate of D			iene _{eg. No.} 2 ()	12	02193
1	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Death	n Dav	Year	3. Time of Death
	Medic Examin	al .	Joan Elizabeth Owens January 9 2012 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De								10:11 AM
أميس	LAdillii	ÇI	5960 Little Road			Lothia			Anne	Arui	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Count	
	3		Usual Residence of Decedent 10a. State 10b. County	72	Town or Loc	ation		09-26-1	939		., D.C. Od. Inside City Limits
	larylan 3a-f sh ified a	Director	MDAnne_Arund		10411 01 200	Lothia	ın				1 ☐ Yes 2 🔀 No
	vith the Maryland 23a or 28a-f show ist be notified at	al Di	10e. Street and Number	-		10f. Zip Code		1	0g. Citizen of V		try?
	ath wit ems 23 r must	Funeral	5960 Little Road 11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. V	20711 Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-		e - Americ	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 Never Married 2 X Married	rmed Forces? ☐ Yes 2 X No Yes, Give		Yes, specify Cubar ☐ Yes 2 🕅 No		Rican, etc.)	Specify:	k, White, e	
21215-0036	hours a	Completed	15. Decedent's Educati		16a. Deced	ent's Usual Occupa	ation	ina	16b. Kind of B	Whi usiness/Ind	
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d 2	led wit Hygiel other ent, th	Be	12 17. Father's Name (First, Middle, Last)		кеат_	Estate Ag	18. Mother's Nam	e (First, Middle, N			
ylan	lid be fi Menta harked atic ev	요	John H <u>oward Log</u>				Julia	Elizabe		rosse	
Mar	2 shouth and the and the strain t		19a. Informant's Name/Relationship (Type, P Frank R. Owens, Sr.,			g Address (Street a				State, Zip C	Jode)
Baltimore, Maryland	of Hea fitem rother		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Rem	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	20c. Location	- City or To	own, State
Itim	it. Page rtment rtant: rjury o		4 Donation 5 Other (Specify)	Woo		Cemeter Name and Addres		3-2012 usch Fur	Galesv		
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licensee	w- M007		325 Mt. I					736
	λ.		23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca	use on each line.			g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
-	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	C49	4				-	
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	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	sate be executed physician and s the burial-transit	I Exa	that initiated events C. – resulting in death) Last	Due to (or as a conseque	ence of):						
092	cate be physic s the bu	edical	d								
Box 68760	ending r use a	Physician/M	23b, was decedent pregnant	If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal	death 3		sy			23d. Date of delivery Month Day Year	
B0)	the att	ıysici		4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)			IVIC	ortun	Day 1eai
P.O.	requires that the death certific been signed by the attending ishould be detached for use as	by Ph	Part II. Other significant conditions contrib	uting to death but not resu	Iting in the u	inderlying cause giv	ven in Part I.				he cause of death?
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of Vi	Physi r this c eral dir	e: 일	1 L Yes 2 No	1 Inpatient 2 I	28b. Time of	nt 3 LI DOA 28c. Injur	4 □ Nursing H y at	ome 5 Resid			y)
on 0	eath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury		Yes 2 No				
Division of Vital Records,	l or Att after d Directa		4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Chook 2 Medical Examiner:	n: To the best of my knowled On the basis of examination	and/or inves	tigation. In my opinio	on, death occurred a	at the time, date a	nd place, and du	ue to the ca	ause(s) and manner stated.
	o the hinting the Figure of th	Me	only one) 8 Certifying Nurse Pr 29b. Signature and title of certifier	actitioner: To the best of m	y knowledge	, death occurred at 1 29c. Licens	the time, date and p	lace, and due to the	ne cause(s) and 29d. Date signe	manner as	stated.
0	KW		1 Amo				1272		1/10/1		
	10		30. Name and address of person who comp	leted cause of death (Item 2 0 3 Mt	23a) (Type,	Chem.	210 0	N.8.1	Mo	21	401
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure				·		
	Registr	ar .	JAN 11 2012 /2	west A Son	to the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELIZABETH HOWARD OWINGS JANUARY 2012 1:25 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CENTREVILLE **OUEEN ANNE COUNTY HOSPICE CENTER** If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Director 214-60-8934 1 M 2 X 1953 MARYLAND NOV. 12, 58 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 X Yes 2 No MD **QUEEN ANNE'S** CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21617 UNITED STATES 116 BANJO LANE, death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. Yes, Give Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working nt of Health and Mental Hygiene.

t: If item 27 is marked other than
or other traumatic event the new life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A -12-Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 MARY FRANCES PEACH MEREDITH DORSEY OWINGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29851 RIVER ROAD, MILLINGTON, MARYLAND 21651 GAIL WEDD OWINGS/SISTER IN LAW 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE' CREMATION 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Department Important: It any injury or STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CENTER Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 408 S. LIBERTY ST., CENTREVILLE, MARYLAND 21617 or complications that caused the death. Do not enter the mode of dying, such 23a. Part 1. Enter the disease Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 19h Physician/ resulting in death) Medical Due to (or as Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Tor in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown Division of Vital Records, P.O. is certificate has been signed by director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) HOSPICE CENTER 6X Other (Specify) Hospital: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 18 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the the only one within To the 29b. Signature and title of certifie 2012 H0057921 Contracelle GOODMA

DHMH 17 Rev 06-2011

State Registrar Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 805 M 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner NNA (AINS If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year **Funeral** Months Days 1274/1947 1 ★ M 2 □ F Mississippi Director 64 215-50-6600 Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director Annapolis Anne Arundel 1 Yes 2 X No Maryland 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21409 USA 705 Whitehall Plains Road the Medical Examiner must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Marital Status Black, White, etc. or i 1 Never Married 2XXMarried ρ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Real Estate Appraiser æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Capen James L. Powell Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Whitehall Plains Road, Annapolis, MD 21409 Susan Powell - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 X Cremation 3 Removal from State 1/10/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility John M. Taylor Funeral Home Myelin T. Wolet 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pm sician/ 30170 C Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Dust to (or as a nonsequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 5 Other (specify) Yes 2 No g 🔲 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 | No ုင္ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated at Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier eputy 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) America ONES ,mo

DHMH 17 Bey 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Patrick Patterson 2012 January 11:30 Å Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Jan.4, 1932 Washington DC 578-38-2683 **Director** 80 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 Bermuda Court 21401 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing 12 Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Gilmore Patterson Mary Agnes Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jane Patterson - Wife 803 Bermuda Ct., Annapolis, MD 21401 Date 12 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 2012 1 ☐ Burial 2 **XX**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) permit. Page Department of Important: If any injury or Lee Crematory Clinton, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XN 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 은 1XX Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XXNatural 5 Pending 1 Yes 2 No Accident Suicide Investigation after death filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho
To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifie 29c. License number 0 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 11 2012

32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

TELAN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 8, 2012^{Year} Donna Mae Pruitt 10:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Rockv111e Montgomery Potomac Valley Wellness & Nursing Ctr Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 107-25-5547 1 🗆 M 2 🖾 F 78 2, 1933 NY Nov. Usual Residence of Decedent show 10a, State with the Maryland # 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a MD Rockville 1 X Yes 2 No Montgomery 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 1235 Potomac Valley Road 20850 USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 → No Specify: Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M€ Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dale Irwin Ada Sortore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Marie DeBlasi/Guardian P.O. Box 10609, Rockville, MD 20849 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place)

Veteran's Cemetery
Cheltenham 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Jan. 12, 4 Donation 5 Other (Specify) <u>Cheltenham, MD</u> 21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home Inc. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) 500 University Blvd. W. Silver Spring. Approximate Interval Between set and Death Ph_sician/ week Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Dementia years Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial and completely filled in by the funeral director, page 2 should be detached for use as the burial remains. signed by the attending physician and defeached for use as the burial and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 XNo 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No Hospita Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) Jan. 9, 2012 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9043 Shady Grove Court, Gaithersburg, MD 20877 Anurita Mendhiratta, 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

JAN 11 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Daniel Leonard Parsons 4:24 P M 2012 Tanuary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hurlock 512 N. Main Street Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 30,1934 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🛣 M 2 🗆 F 213-32-2682 Director Maryland March Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director Dorchester Hurlock 1 X Yes 2 No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21643 Funeral 512 N. Main Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1 XYes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Construction Union Carpenter Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice Muriel Zittle Edgar H. Parsons permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 N. Main St., Hurlock, MD 21643 Wilda Parsons/Spouse Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Hurlock, Maryland 01/17/12 4 ☐ Donation 5 ☐ Other (Specify) Eastern Sh. Veterans Cem. 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Federalsburg, MD 21632 216 N. Main St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINDIL Physician/ TONOUR ALIGNANT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any leading to immediate Examine if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to jor as a consuluence of attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? Yes 2 100 within 24 hours after death.

To the Funeral Director, After this certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ၉ 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury → Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

BUP

22 Registrate Signati

29c. License number

noos 840

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Delores Ann Proctor 2012 1103 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 👿 F DEC 27. 1960 Director 214-86-6264 51 Maryland Usual Residence of Decedent 23a or 28a-f show st be notified at should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Ceci1 Earleville 1 X Yes 2 No |Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a rent, the Medical Examiner must ! 95 Peddlers Lane 21919 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Manager Loan Financing Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ည Gary L. Davis Delores Aro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Joseph C. Proctor/Husband 95 Peddlers Lane, Earleville, MD Department of Heall Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Januarv 4 Donation 5 Other (Specify) E1kton Cemetery 26, 2012 Elkton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death .Physician/ williac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Due to (or as a consequence of) transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year be detached 9 🗌 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, Completed 1 Tes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No Other: ပ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending within 24 hours after death

To the Funeral Director: /
completed filled in by the I Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2. 29b. Signature and title of certifier 29c. License number 23/12 45502 Gules MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlo E. Gopez, M.D.

Registrar DHMH 17 Rev 7/2009

State

38

31. Date filed (*Month, Day, Year*) **JAN 3** 0 2012

Cathelial

Street

32. Registrar's Signature

Elkton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1/04/12 Emilie G. Rankin 401am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Denton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Envoy Health Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 M 200 214-05-0086 Director 95 8/11/1916 Washington, DC Usuai Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 28a-f show 1 Yesx2 No Examiner must be notifled Director Anne Arundel **Annapolis** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the IM dieal Examiner must be no gone. Funeral 245 Cape St. John Rd. 21401 USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 😾 No White Specify: þ 3 ☐ Widowed 4 ☑ Pivorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carroll George Hatty Dammer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 245 Cape St. John Rd. Annapolis, MD 21401 Bolton Rankin Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition txxBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Bluff Cemetery 1/9/2012 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 12 Ridgely Ave. Annapolis, Md 21401 Approximate Interval Between Onset and Death immediate Cause (Final Physician end resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal dea
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetai death 3 ☐Ectopic pregnancy in the past 12 months' Month Day Year be detached for 5 Other (specify) ☐Yes 2 No the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 ☐ Yes this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) am notes of 3683 Chapterk Rd But 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 9 2012 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan. 2. 5:26 P M 2012 Rhine Richard Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 10442 Claiborne Road Claiborne . Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 04-05-1947 Months Days Hours Min. PA. 198-38-3062 Director Usual Residence of Decedent 28a-f shov notified at 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Md. Talbot Claiborne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be Funeral 21624 23a 10442 Claiborne Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Never Married 2 Married Black, White, etc. ō Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Il Hygiene. should be filed within 72 h and Mental Hygiene.
7 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Business Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James H. Rhine Jane Rementer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $10442\ Claiborne\ Rd.\ Claiborne,\ Md.\ 21624$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Alice Rhine / Wife Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Crem. of Delmarva 01-04-2012 Delmar, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee HardeydadOstrowski Funeral P.O. Box 518 St. Michaels, Liosan m. OSTROWSKE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ OITTHOSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 🗌 No 9 Unknown 9 I Hinknown Division of Vital Records, P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2- No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 2 has autopsy performed certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2- No မ 1 Inpatient 2 I ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioners To the best of my knowledge, death occurred at the fine, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

State Registrar

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29b. Signature and title of ce

30. Name and address of persor

31. Date filed (Month, Day, Year)

5 2012

Robert Sanchez M.D. 508 Idlewild Ave. Suite#5 EAston, Md. 21601

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Physician/ Rotwein 11:15 A^M Frances 2012 January . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 6605 Tulip Hill Terrace Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 147-16-1299 **Director** 1 □ M 2 👺 F 10/20/1920 Pennsylvania 91 Yrs. Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1X Yes 2 ☐ No Bethesda MD Montgomery 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number items 23a or ner must be n 9 Funeral United States 20816 6605 Tulip Hill Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within I Hygiene.

'ther than "r, the Me-" Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Executive Assistant permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ഉ Elizabeth Lake Walter Kirk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Rotwein / Son 14000 Coastal Highway #803 Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 01/07/2012 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. any in 5130 Wisconsin Ave. Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Months Immediate Cause (Final Physician Metastatic Adenocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the phy attending ph d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Year Month Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 certificate has death?
1 Yes 2 Y No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician:

within 24 hours after deaun.

To the Funeral Director: After this of

Suicide 4 \square Homicide

31. Date filed (Month, Day, Year)

JAN 1 1 2012

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1/06/2012

12890

28f. Location (Street and Number or Rural Route Number, City or Town, State)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon M. Wiseman MD 5410 Connecticut Avenue NW Washington, DC 20015

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

10

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month RODRIGUEZ Physician/ January BERTHA 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** CAMBRIDGE HUSPITAL DORCHESTE GENERAL ORCH ESTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Hopths | Davs | Hours | Min. | A (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** May **Director** Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No 9 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 0 by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 ₩Widowed 4 Divorced 1a CK permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) //Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) eon Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Bethe Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses MD.21613 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician/ STAG ND disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav ☐ Pregnant ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 05, 2012 D69234. 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE 21613. MD JEEVAN ERRABYLU STREET 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 I 2012 :40 PM Raven Michelle Roberts. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Pocomoke 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 🗆 M 2 🕱 F Days (Month Day Year) 8 **Director** 220-90-8017 33 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d, Inside City Limits MD Pocomoke Worcester 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 624 Cedar St., Apt. A. 21851 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black White etc "natural", or Completed by 1 Never Married 2 Married Yes 2 No If Yes Give 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify Black Year or Dates 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) Manager Fast Food is marked other Be Maryland Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Roberts Caroline Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 681, Pocomoke, MD 21851 Anthony B. Harsey / Step Father timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🔲 Removal from State 1/14/2012 Mt Sinai Cemetery Pocomoke, MD 4 Donation 5 Other (Specify) uneral Service Licenses Signature 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ARDIOMYEPAT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last the bunal-trar Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 1 Live Birth 2 Fetal death yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 17 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director. 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8.0

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31. Date filed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Patrick Ritchie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Hours 217-54-6508 September 20, 1949 62 Director 1**X** M 2 □ F 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director Lonaconing Yes 2 No Maryland Allegany 10e. Street and Number rms 23a or 9 10f. Zip Code 10g, Citizen of What Country Funeral 21539 **USA** 33 Robin Street items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces:

Yes 2 [If Yes, Give Year or Dates.] Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Owner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **Dolores Monahan** Glen Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33 Robin Street, Lonaconing, Maryland, 21539 Jeannie Fuente - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dianuary 27. 1 Burial 2 Cremation 3 Removal from State Frostburg Memorial Park Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Eichhorn-McKenzie Funeral Home P.A 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_si_ian. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine and resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death detached been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No I ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Y** Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Manahan (

JAN 3 0 2012

31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

Cumber and

32. Registrar's Signature

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			For State	State of M	arylan		artment of H		and M	_	-	001	2	02207
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cer	tificate of L	Jeath		2. Date of De		. ZU I	6	3. Time of Death
ı	Physicia Medio		JANET M	. SCHE	COED	ER				Month	21	ay Ye	ar	03:20AM
and the last	Examir		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, o				40	c. County of [
	Funeral		Calvert Memorial 5. Social Security Number 6. So	7. Ag	e (In yrs. Ia	ast birthday)	Prince F			8. Date of Bir	th	<u>Calve</u>		lace (State or Foreign
	Director		220-0/-6323	□ M 2 X □ F	90	Yrs.	Months Days	Hours		Nov. I		21	Count	
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			-			11	Od. Inside City Limits
	Maryla 28a-f s otified	Director	Maryland Baltimo	ore		Roseda	le-Baltin	nore (Count	У				1 ☐ Yes 2XXNo
	filed within 72 hours after death with the Maryland at Hyglene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		10e. Street and Number				10f. Zip Code	01.00	7		10g. C	itizen of Wha	t Coun	try?
	ath wi	Funeral	6512 Langdale Rd	12. Was Decedent	ever in U.S	3 113 1	Nas Decedent of H	2123		ify Yes or No-		USA 14. Race - A	\ maria	on Indian
စ္က	fter de , or its amine	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X		1	Was Decedent of H			tican, etc.)		Black, V		
000	ours at	eted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.			I ☐ Yes 2x(x)No					Specify:	Wh:	
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and	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	Markol						(First, Middle,		Surname)		
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	1 and 2 sl of Health a item 27 is other tra		Dennis Schroeder	(Son)			Cassell							•
Baltimore,	ge 1 and of Hill items or oth		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐	Removal from State	C	emetery, cren	sition (Name of natory or other plac	ce)	_	ate		ocation - Cit	-	
ltim	t. Pa tmel tant tant jury		4 ☐ Donation 5 ☐ Other (Specif 21. ᢓfgnatylre of Funeral Service Ligens		но		11 M. G.		1-30-	sahn F		Ltimore		1d.
Ba	Depar Impor any in		Locatha tos	Sch. C			401 Bela							
			23a. Part 1. Enter the disease, or company shock, or heart failure. List only o	olications that cause ne cause on each line	the deat	h. Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between
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	Examiner			Due to (or as			itis						<	: I week
0.	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ience of):								1 week		
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Box 68760	The law requires that the death certificate be attending bhysici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE:	d							1			
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SCO	has be	Completed	Dementic							24a. Was autoj	psy	prior	to cor	sy findings available npletion of cause of
E B	sician: The law r certificate has b irector, page 2 s	e Co	25. Was case referred to medical				26 DI	ace of Dea	oth (Chools	1 Tes	2 V N	lo 1 🗆		2 🗆 No
Division of Vital Records,	nding Physician: 1 th. After this certifics funeral director, f	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatier	Oth	er:		ne 5 🗌 Resid	dence	6 ☐ Other (S	(pecify	
J Of	ing Pt		27. Manne of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ry y, Year)	28b. Time of injury	28c. Injur work	y at :?	2	8d. Describe h			, ,,,	
sior	Attending or death. sctor: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b	9	ırv - At ho	me, farm, str	M 1 L	Yes 2		8f Location (9	Stroot ar	ad Number o	r Rural	Route Number,
Divi	tal or /		4 ☐ Homicide determined	building, et			set, ractory, emige			City or Tov			riurai	noute Number,
2	the Hospital or nin 24 hours afte the Funeral Dir npleted filled in	Medical	29a. Certifier 1 Certifying Physical Check 2 Medical Exami	sician: To the best of ner: On the basis of e	my knowl	ledge, death of	occured at the time	, date and on, death or	place, and ccurred at t	due to the ca	use(s) a	nd manner as e, and due to	s stated	d. se(s) and manner stated.
2)	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Ĭ	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the	best of my	y knowledge, o	leath occurred at th	e time, date	e and place	, and due to th	e cause	(s) and manne ate signed (M	r as sta	ted.
			► (nshah/138m	MIMIT	SHE	M, MO	07	2609	6		01	122		
	Ø		30. Name and address of person who c	completed cause of d	eath (Item	23a) (Type, F	Print) D		200-1	erick	. 100	0 3	7/^-	10
7	Sta	te.	31. Date fligd (Month, Pay Year)	32. Regiger	ar's Signat	ture _	u rin	14	NYCH	CHICK	111	in al		18
	Registra		JAN 3 0 2012 2	un d.	Ba	Mes								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02208 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Virginia Sharpe OTT 13/2012 7 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8 Date of Birth Funeral 1 🗆 M 2 😾 F Days Hours 0571971921 233-34-5758 90 West Virginia Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Chesapeake Beach 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4130 Pinewood Terrace 20732 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☐ X lo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative National Geographic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wade Snyder Marcella Shell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrel Sharpe - son 4130 Pinewood Terrace Chesapeake Beach MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Greenwood Cemetery 01/16/2012 Lost River West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home Signature of Funeral Service Licenses SKa 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15 years Immediate Cause (Final Physician/ disease or condition resulting in death) <u> Atherosclerosis</u> Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Parkinsons Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01/13/2012 D31563

- KM

State 31. Date filed (Month, Day, Year)
Registrar JAN 12 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Benner, MD 20945 Great Mills Road Suite 203 Lexington Park MD 20653

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	aryland /		tificate of L		ı ivlental Hy	Reg. No. 2	2012	02209	
Г	Physicia Medic	n/	1. Decedent's Name (First, Middle, Nicki	Last) Carol		Sta	mper		2. Date of De Month Januar	Day	012	3. Time of Death 5:15 A M	
	Examin		4a. Facility Name (if not institution, g	rive street and number)			4b. City, Town, o	r Location of De	ath	4c. Co	unty of Death		
لعميني			College View Cer	nter			Frede				ederic		
	Funeral Director	7	5. Social Security Number 220–70–2890 Usual Residence of Decedent	i. Sex 7. Age 1 ☐ M 2 ☐ F	e (In yrs. last bii 52	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		ay, Year)	Cou	nplace (State or Foreign ntry) yland	
	and show	ò	10a. State 10b. County		10c. City, Tov	n or Lo	cation	1				10d. Inside City Limits	
	Maryla 18a-f	Director	Maryland Frede	rick	New M	arke	t					1 🗌 Yes 2 🗓 No	
	with the I	Funeral Di	10e. Street and Number 5556 Sponseller	Court			10f. Zip Code	1774			n of What Cou USA	untry?	
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🎦 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Was Decedent of F f Yes, specify Cuba Pyes 2 No		(Specify Yes or No erto Rican, etc.)		Race - Ameri Black, White, ecify: Wh		
215-0	iin 72 hou ie. han "natu e Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	grade completed)	Completed)		dent's Usual Occup kind of work done O NOT use retired)	during most of w	_		of Business/li		
121	d with tygien ther th	ادها	17. Father's Name (First, Middle, La			LXE	cutive A		Name (First, Middle			ment	
ylanc	ld be filed Mental Hy iarked oth atic event	To E	Harris B.	Eskin				Carol	Q.	Gro	svenor		
, Mar	d 2 shou alth and n 27 is m er traum	Ì	19a. Informant's Name/Relationshi Carol Eskin (Mo	ther)	17	07 N	ng Address (Street lerry-Go-	and Number or Round W	Rural Route Numb ay, Mt.	er, City or To	MD 217	71 (Code)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injuy or other traumatic even once.		20a. Method of Disposition 1 ☐ Burial 2 🏖 Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place cemet Stauf	of Dispo ery, crer fer	esition (Name of matory or other pla Cremator	се) У 1/	Date 12/2012		tion - City or T		
Balti	permit. Departn Imports any inju		21. Signature on Funeral Service Liv	en en en en en en en en en en en en en e					tauffer BLvd, Mt				
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										Approximate Interval Between Onset and Death			
The state of	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										
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	sate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):	- · · · ·						
092	tte be (hysicia the bur	edical	•	d	· · · · · · · · · · · · · · · · · · ·								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 to do 9 Unknown	1 Live Birth	3c. If yes, outcome of pregnancy 1			су		23	23d. Date of delivery Month Day Year		
, P.O.	es that the signed by	by	Part II. Other significant condition		out not resulting	j in the u	underlying cause g	iven in Part I.				the cause of death?	
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Re	: The icate l								1 🗆 Yes	2 No	1 🗆 Yes	2 No	
Ital	siciar certif irecto	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/0	D	Lou	Place of Death (C	g Home 5 Res	-: 6 [Other (Speed	(6.)	
η of V	ing Phys I. After this funeral d	ate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	ry 28b	Time o injury	f 28c. Inju	ry at	28d. Describe				
Division	l or Attence after death Director;	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 280 Place of Ini	ury - At home, c. (Specify)	farm, str	reet, factory, office	i les ZEINO		(Street and Nown, State)	Number or Rur	ral Route Number,	
	e Hospita 124 hours e Funeral letely filled	Medical	(Check 2 Medical Ex	Physician: To the best of caminer: On the basis of c Nurse Practitioner: To th	xamination and	/or inves	stigation, in my opin	ion, death occurr	red at the time, date	and place, a	nd due to the o	cause(s) and manner stated.	
	To th withir To th сотр	2	29b. Signature and title of certifier				20c Licen	ao numbor		20d Data	sianod (Month	Day Vearl	
) Ue	MB			D6	0417		1-	9-20	12	
	10		30. Name and address of person v	ho completed cause of c	leath (Item 23a) (Type,	Print)		211	Fire 1	0,11	21702 MD	
			Hemen 5 hc 31. Date filed (Month, Day, Year)	XL 32 Radictr	ar's Signature	an	as 101	meon	DY,	1 259	WICE	(-I)	
	Sta Registr		JAN 1	1 2012 En	was h	9. 1	parked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2012 SKAGGS 6:00P. M LINDA January 6, 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick 8318 Sharon Dr. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours 231-66-4793 1 🗆 M 2 🛛 F 65 April 10,1946 Tennessee 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21704 8318 Sharon Dr. United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Nursing Health Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Mae Johnson Gates Walter Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8318 Sharon Dr./Frederick, Maryland Hiram H. Skaggs, Jr./ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 01/11/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Lice 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Prysician Medical Examiner

permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve

Examine Be Completed by Physician/Medical State

Physician/

Medical

Director

Funeral

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Completed

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Examiner

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Director

th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P

Medical Certificate:

29b. Signature and title of

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition	cole cause on eacysine.	Onset and Dear	th 2 0				
resulting in death)	Due to (or as a conse, uence of):						
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that initiated events resulting in death) Last	ents C.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year	r				
1/ //	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Universe autopsy findings availing performed? 1 Yes 2 No 1 Yes 2 No	known				
25. Was case referred to medical	26. Place of Death (Check	only one)					
examiner? 1 \sum Yes 2 \times No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 🔀 Residence 6 🗆 Other (Specify)					
27. Manner of Death Natural 5 Pending Pend	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	# 28a Place of Injury - At home farm street factory office	8f. Location (Street and Number or Rural Route Number, City or Town, State)					
(Check 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and iminer: On the basis of examination and/or investigation, in my opinion, death occurred at urse Practitioner: To the best of my knowledge, death occurred at the time, date and place	he time, date and place, and due to the cause(s) and manne	er state				

State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 4 12:30 A M Physician/ Month 1 Timothy J. Samuel Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Howard** 4b. City, Town, or Location of Death Examiner Gilchrist of Howard County Columbia Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birtholace (State or Foreign **Funeral** Hours Min 151-76-4573 1**¥** M 2 □ F Director 52 7-4-1959 India Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Ellicott City 1 Yes 2 X No MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21042 2396 Ballard Way United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify**Asian Indian** Completed 3 Widowed 4 Divorced Year or Dates other than "natur 16b. Kind of Business/Industry
Information 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the None. Technology Database Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Juliet Samuel Jeyaraj Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2396 Ballard Way Ellicott City, MD 21042 Nancy K. Timothy/wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/16/12 Marriottsville, MD View Cemetery Signature of Fun ral Service Lice see 22. Name and Address of Facility Harry Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Days to for as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Month Pregnant at time of death ed by the a 9 Unknown g Unknown ate has been signed bage 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 M No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this by the funeral 28c. Injury at work?
1 Yes 2 No Certificate: . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 24 hours after deal Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hc

To the Fun

completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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egistrar's Signature

escul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00060634

COLUMBIA

Please Type or Print in Black Indelible Into Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 4:50 Hansel R. Staley January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Northampton Manor 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 🚰 M 2 🗆 F Director 216-22-9954 12/21/1921 MD 90 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Walkersville MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a of Examiner must be Funeral USA 21793 1 Maple Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 'natural", 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) coca cola truck driver 10 traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental I ဂ္ Virgie Michael Harry M. Staley Virgi Michael and 2 should be Henry M. Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Maple Ave., Walkersville, MD 21793 Gloria Staley/wife other 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of Important: If it any injury or o 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2012 | Frederick, MD Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear valid. e. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ YEMS disease or condition resulting in death) ALZHEIMERS DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months? Month Day Pregnant at time of death 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by No 3 ☐ Probably 4 ☐ Unknown 1 Yes CROW'S DISPASE should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 After this certificate has 1 Yes 2 No Yes 2 N filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funer

completely fi 29a. Certifier (Check the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: 7 only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Po BOX 2:753 RICUMD WALKERSUILLE MAD GOVEH

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month January Physician/ 2012 3:40 РМ Lenora Sawchak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 200-26-6767 77 **Director** 1 🗆 M 2 🕱 F Sept 1, 1934 Pennsvlvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Maryland Frederick Frederick 1 🗌 Yes 2 🔀 No 10f. Zip Code 21701 10g. Citizen of What Country? 10e. Street and Number 3030 Mill Island Parkway Funeral items 23a 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2XXMarried ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 White Yes, Give 1 ☐ Yes 2X No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jefferson Stevens Susan Carino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>. 2</u> 21701 3030 Mill Island Parkway, Frederick, Maryland Health a Peter Sawchak - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cathedral Cemetery 1-16-2012 \$cranton, Pennsylvania 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dang, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? 1 Yes 2 No 9 Unknown for Month Day Year ☐ Pregnant at time of death ☐ Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsv death? Yes Be (Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 Z No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. within 24 hours after death. To the Funeral Director, After (Month, Day, Year) 1 Natural 5 Pending injury 2 No 1 Yes Accident Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar
DHMH 17 Rev 06-2011

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State

Name and addr

31. Date filed (Month, Day Year)

of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

	Ame	n d	State 1 Regisfarar FH, TCHI	State of Marylan , pha 1/23/						Reg. No.	012	02214
			1. Decedent's Name (First, Middle, Last)		12.00.				2. Date of Dea		Year,	3. Time of Death
	Physicia Medic	al .	william Dav	rd Sand				f Da ath	1	<i>Q</i>	16	O / II M
	Examin	er	4a. Facility Name (if not institution, give si	Mary (d. rel		46. City, Tov	wn, or Location	AAYR		4c. Cou	nty of Death	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Months	Year If Un-	der 24 Hrs.	8. Date of Birt	h vYear)	9. Birth	place (State or Foreign try)
	Director		212-86-3680 Usual Residence of Decedent	M 2 □ F 48	Yrs.	Mondis	Jayo	1,1,11,11	1-22±, P3	637		MD
	show at	ō	10a. State 10b. County	10c. City	y, Town or Loc	cation					1	0d. Inside City Limits
	Maryk 28a-f : otified	Director	MD Talbot	Tr	appe							1 Yes 2 No
	th the	al D	10e. Street and Number	D A		10f. Zip Co	ode 21673			10g. Citizen USA	of What Cour	ntry?
	ems 2	Funeral	31426 Bruceville	12. Was Decedent Ever in U.S	3. 13. V	Nas Decedent	nt of Hispanic	Origin? (Spe	ecify Yes or No-	14. [Race - Americ	
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It me 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		f Yes, specify			Rican, etc.)		Black, White,	1
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ylar	should be fill and Mental 7 is marked or raumatic eve	P	David P. Sard Sr						M. Andr			
Mar	12 shoulth and 27 is n		19a. Informant's Name/Relationship (Typ			ng Address (S 6 Bruc			al Route Numbe Trappe,			Jode)
re,	of Heal of Heal fitem		20a. Method of Disposition	ife) 20b. F	Place of Disno	eition (Name	of	1 7	Date Date		on - City or T	own, State
imo	Page ment of ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Ch	emetery, cren esapea Ce	ke Cre nter	mation	1/9/	2012	Steve	nsvill	e, MD
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If i any injury or once.		21. Signatur of Fall Service License	14 tomally	11/2	00 S.	Harris	son St	Easto	n MD 2	neral 1601	Home, P.A.
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ications that caused the deat e cause of each line	h. Do not ente	er the mode o	of dying, such	n as cardiac o	or respiratory ar	rest,		Approximate Interval Between
Immediate Cause (Final disease or condition a									arsaise)		Onset and Death
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		iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):							
	sud and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of:							
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39 ×	th certi tendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 Live Birth 2 Fet	al death 3 [Ectopic pre				23d	. Date of delive	very Day Year
Box.	the at the at	ysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of 9 Unknown	death 5 L	Other (spec	спу)					
P.O.	that the need by e detail		Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	underlying car	use given in l	Part i.				the cause of death?
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f Vii	Physic this or ral dire	은	1 ☐ Yes 2 No 27. Manner of Death	lospital: 1 Anpatient 2 28a. Date of injury	ER/Outpatie		Other: 4 [Nursing Ho	ome 5 Res			5))
0 0	nding I th. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	м	work?	2 🗆 No	200. Describe	now injury oo	ounou.	
Division	or Atter after dea Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	reet, factory, o	office			Location (Street and Number or Rural Route Number, City or Town, State)		
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Cheek 2 Medical Evamin	ician: To the best of my knowner: On the basis of examination Practitioner: To the best of	on and/or inves	stigation in my	v opinion, dea	ath occurred a	at the time, date	and place, an	d due to the c	ause(s) and manner stated.
	To the To the comple	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	Practitioner: To trie best of	my knowledge	29c. l	License numl	ber			igned (Month	
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	_		30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type,	Print)	(-00)	2WO.	Stroi	t. Pan	(Jours)	יור אולו אף
	5 Sta	te	31. Date filed (Month, Day, Year)	62. Registrar's Sign	ature	1714	U IEU		0110	-0 172		· · · · · · · · · · · · · · · · · · ·
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Schumacher Raymond K. 2012 7:57 A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 86 8. Date of Birth (Month, Day, Year)
Mar. 18,1925 Months Hours 282-20-6159 **Director** Ohio 1 X M 2 🗆 F 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Severna Park MD Anne Arundel 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21146 588 Old County Road was Decedent Ever in U.S. rmed Forces?

X Yes 2 No 1943-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates White 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced Completed 1946 event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Olivia Hilty Cyrus Schumacher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 588 County Road Severna Park, MD 21146 Margaret Jane Schumacher/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 17, Important: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Crownsville, MD MD Veterans Cemetery 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral He 495 Rithcie Hwy, Severna Park, MD 21146 23a. Part 1. Egter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PEA Physician/ disease or condition arist BILLIAM Medical resulting in death) Due to (or as a consequence of) Examiner CARDIOMTOPATH Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exam requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: ISe 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ninknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? HIN 24a. Was an has autopsy performed certificate PROSTATE CANCER 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 patient 2 ER/Outpatient 3 DOA ပ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \sum Yes 2 \sum No 1 Natural 5 Pending injury n 24 hours after death. le Funeral Director: Afi bletely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 To the I the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2 219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+1 PATES \sim 0 31. Date filed (Month Nay, Year) 2012 Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Gregory Robert Sears** 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0330 hrs January 6, 2012 **Medical Examiner** Gregory Robert Sears 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** University Shock Trauma If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director 215-17-4632 36 1975 Country) MD 1 X M 2 F Dec. 11, Usual Residence of Decedent 10d. Inside City Limits in 10a. State 10c. City, Town or Location 1 Yes 2 No or 28a-f show MD Anne Arundel Laurel Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8031 Ians Alley 20724 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No Specify: White 3 Widowed Divorced f Yes. Give Year 1 Yes 2 X No specify: 6 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Medical Billing Medicaid Advocate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Sears Marilyn English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Laurel,MD 20724 Sarah R. Sears/Wife Ians Alley, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State Lakêmont Mem. Grdns. 1-11-2012 Davidsonville, MD Donation 5 Other Specify: 22. Name and Address of Facility Signature of Furieral Service Linux Beall Funeral Home 6512 NW Crin Hwy, Bowie, Maryland 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician **Retween Onset and** failure. List only one cause on each line /Medical Death a. Gunshot Wound of Torso Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Fetal death past 12 months? Pregnant et time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been s page 2 should t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month Day,Year) Jan 6, 2012 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury After Subject shot Certification Natural 0222 hrs 1 Yes 2 ✔ No Pendina Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 8031 lans Ally, Laurel, MD To the Funeral E determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registra

31. Date filed (Month, Day, Yea

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Pegistrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E

January 6, 2012

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JMAnth 8, 2012 8:25pm M Physician/ Dorothy Amber Sievering Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery 4952 Sentinel Dr Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Days (Month, Day, Year) 88 Hours 152-14-1605 1 🗆 M 2 🖁 F Director May 31,1923 Muskogee, OK Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a, State Director 1X Yes 2 ☐ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20816 4952 Sentinel Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White Yes. Give "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates the Medical 5. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. 4 College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ျ Lou Redpath Harry Rothberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Candytuft Ct, Rockville, MD Nelson Sievering III/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or Important: If any injury or 1-10-2012 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Funeral Service Acensee 22. Name and Address of Facility Joseph Gawler's Sons, INC Signatur M 5130 Wisconsin Ave, N.W. Washington DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1 Onset and Death Years Immediate Cause (Final Physician/ Bronchiogenic Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dos to for as a consequence vita certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician use as the buris Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death ło in the past 12 months?
1 Yes 2 XNo Month Year Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral director, page 2 נ autopsy performed 1 Yes 2 2 death? 1 ☐ Yes 2▼ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 XNo 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter G. Hamm MD 5530 Wisconsin Ave. Chevy Chase, MD 20815

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature

(Check

d title of certifie



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32033

29d. Date signed (Month, Day, Year)

01/09/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMnth ^D2^V012 9, 10:45 PM FELICIA SNEAD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday **Funeral** Hours Days 579-48-0724 1 □ M 2 🔽 F 90 VENEZUELA Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MONTGOMERY SILVER SPRING MD. 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Hygiene. other than "natural", or items 23a o Funeral 1418 FLORA TERRACE 20901 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X No If Yes, Give should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No SpecifWENEZUELAN Specify: WHITE 3 Nidowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) YRS SOCIAL SECRETARY **EMBASSEY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CEFERINO ROJAS JULIETTA PEREZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERIC SNEAD - SON 1418 FLORA TERR., SILVERSPRING, MD. 20901 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ARLINGTON NAT. CEM 1/27/2012 ARLINGTON, VA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Service Licensee WASHINGTON, DC 20007 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ZHEIDVA DUNCATUR Medical resulting in death) Due to (or as a consequence of): Examiner ARLKINSONS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence of) Cause (Disease or linjury that the death certificate be executed and that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 12 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Investigation Accident Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AN THO NY

7 2012

31. Date filed (Month, Day, Year)

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JANUARY

MD

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Howard Ricardo Sampler	State of Maryland / Department of Health and Mental Hygiene

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			Registrar	Cer	tificate of	Death			Reg. N	No.		Sum Com 4
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			Prince George's Hospital Ce			Cheverly				Prince Ge		
	uneral irector		5. Social Security Number 6. Sex 578–19–4284	7. Age (In yrs. la			ear If Under ays Hours	Min		F	9. Birthplace (State foreignWashir Country) D. (noton.
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စ် .	Heal Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3		Place of Dispos rematory or oth	ition (Name of one of o	cemetery,	Date	20	c. Location - Ci	ity or Town, State	
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		cia	past 12 months?	4 Pregnant at time of dea	ath	her (Specify)			- 1		,	
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	.		30. Name and address of person who cou	noleted cause of death (Item	23a)							
e 1	,		30. Name and address of person who con Victor Weedn MD JD Ass	npleted cause of death (Item istant Medical Examin		. Baltimore	Street, Ba	Itimore, MI	21223			
2 1	/	tate			er 900 W	/. Baltimore	Street, Ba	Itimore, MI	21223			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death Physician/ ERNESTINE 8 2012 8:15 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner CITIES CENTER RIVERDAL PRINCE 8. Date of Birth (Month, Day, Year) 07–12–1930 9. Birthplace (State or Foreign Country) Washington, DC Min. Months Hours 579-38-2582 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No Washington DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 20020 1931 S Street, SE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Teacher DCPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Travers Ada M. Alfred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1931 S Street, SE Washington, DC James H. Slade - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 01-17-2012 Brentwood, Maryland 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Licens Canadol 10583 Middleport Lane, White Plains, 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCUL disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner Due to lor as a conse quence of cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\text{No}\) 1 ☐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 00 မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury Natural 5 Pending Investigation Accident

signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 After this certificate has been funeral director,

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Page 1 and 2 should {
Department of Health and Me
Important: If item 27 is mark

other

injury or

any

Physician

Medical

Examiner

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certificate:

Medical

3 Suicide
4 Homicide

(Check only one)

To the Hospital or Attendir within 24 hours after death. To the Funeral Director. At

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mpleted cause of death (Item 23a) (Type, Print)

6 Could not be

determined

DR. ELKRIDGE, MARYLAND 21075

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month FRANCIS DONALD TARLETON JANUARY 2012 9.05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Days Hours Min (Month, Day, Year) Director 212-30-3869 1 ▼ M 2 □ F 78 May 8, 1933 Maryland Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 X Yes 2 No <u>Maryland</u> Frederick <u>Frederick</u> ō 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 5691 Crabapple Drive 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 XMarried Black, White, etc. Yes 2 XNo "natural", or by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Foreman Manufacturing is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file Malcolm Tarleton Mary Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s tem 27 i Doris Tarleton / Wife 5691 Crabapple Dr., Frederick, MD 21703 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mary's Cemetery 1/14/2012 Petersville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1 Enter the disease, or complications that chiefe the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 0513 disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Syndrone Muelod Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co Exami The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 certificate 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No 힏 Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month,

deric

Fre

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A.

MO 51610

Tolino,

29d. Date signed (Month, Day, Year)

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			For State Registrar		State of M	arylan		artment of F <i>tificate of L</i>	Health and N Death		liene Reg. No.	12	02222
	4-1.		Registrar Decedent's Name (F	First, Middle, Las	t)		001	tinoato or z	- Journ	2. Date of Dea	th		3. Time of Death
	Physicia Medic		MABEL CAI							January			0350 м
Sind	Examir	er	4a. Facility Name (if no.	1 Hospi				Easto			4c. County		
1	Funeral Director		5. Social Security Number 220-03-384 Usual Residence of D	43 1	7. Ag	94	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthr Co <i>un</i>	olace (State or Foreign try) MD
	and show dat	tor		Db. County		10c. City	, Town or Lo	cation)			1	0d. Inside City Limits
	Mary 28a-f otifie	Director	MD	Talbo	t	E	aston						1 X Yes 2 □ No
	/ith the 23a or st be r		10e. Street and Number		gton Stre	o t		10f. Zip Code 21601			10g. Citizen of USA		ntry?
980	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show er than Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 3 X Widowed 4	2 Married	12. Was Decedent & Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	ver in U.S			ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Americ ck, White,	etc.
2-0	2 hours	plete		5. Decedent's Ed only highest gra	lucation			lent's Usual Occupa	ation during most of worki	ina	16b. Kind of E	Business/Inc	dustry
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lary	1 and 2 should be f Health and Mer item 27 is marke other traumatic		19a. Informant's Name			hter)	19b. Mailir	ng Address (Street a	and Number or Rura				
	and 2		Carolyn A		ughgood	20h P		Quintynne sition (Name of		Greenv	ille, I		
altimore,	ent of ent of nt: If it			Cremation 3	Removal from State	CE	emetery, cren	natory or other plac Mem. Parl	e)	-2012	Easton		JWII, State
altii	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Funera			1,100			<u> </u>				Home, P.A.
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	Medical Examiner Lial-transit	Examiner		ailure. List only or al	a. Due to (or as Due to (or as	a consequ	ence of):	Henor	10				Approximate Interval Between Onset and Death
	death certificate be ne attending physicie ed for use as the bu	/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 Yes 2 Number 19 Unknown	egnant htths?	4 Pregnant a 9 Pregnant a	of pregnar 2 Fetal t time of d	ncy I death 3 = eath 5 =	Ectopic pregnanc	,		Mo	ate of delive	Day Year
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Division of Vital Records,	requi been shoul	Completed								24a. Was a autops	n 24b.	Were autor prior to co death?	psy findings available mpletion of cause of
al F	ian; Ti ertifical ctor, p		25. Was case referred t	100				26. Pla	ace of Death (Check	1 L Yes	2 NO	1 Yes	2 LI NO
Ę	Physic this ceral dire	은	1 ☐ Yes 2 N 27. Manner of Death	lo	lospital: Inpati		ER/Outpatier		4 L Nursing Ho)
0 0	nding l th. : After e funei	cate		Pending Investigation	(Month, Day		injury	28c. Injury work M 1 \square		28d. Describe ho	w injury occurr	red	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	d Certificate:		Could not be determined	28e. Place of Injubulding, etc			eet, factory, office		28f. Location (St Gity or Town		er or Rural	Route Number,
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	vitt To con		29b. Signatureland title	17 1	N.O.				86565G	- 2	9d. Date signe	d (Month, I	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Add Janua 50 n Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pediatric 15 a 6. Sex Itimore Kuspite If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Min (Month, Day, Year) **Director** 1 🗆 M 2 🔀 F 2011 2? 28a-f show 0a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director TOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ISA 21620 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, , or ! ģ 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event. the Mea Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Chestertown. Taylor - Mother 202 Dutches 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 7-2012 4 Donation 5 Other (Specify) FELLOWS Helfenbern and Newn 130 Speer Rood Chestertown and Newham Funcial Home, P.A. 21. Signature of Funeral Service Licensee Rich of of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Nemali disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Po in the past 12 months?
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To the Funeral Director: After this certific completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 🗶 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Interval Between Onset and Death month 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 21209 Llow 1708 Registra s Signature State Registrar DHMH 17 Rev 06-2011 ORIGINAL

3. Time of Death

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9. Birthplace (State or Foreign

10d. Inside City Limits

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DHMH 17 Rev 06-2011

State Registrar 31. Date filed *(Month, Day, Year)*

			State		artment of Health and	l Mental Hyg	iene	2 02225
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	2. Date of Death	eg. No. 201	3. Time of Death
	Physicia Media		Charlotte Thorpe			Month O	Day 04 Year	2 14:21 PM
garina, magan	Examir		4a. Facility Name (if not institution, give street and number) Vaiversity of Maryland Medical	Center	4b. City, Town, or Location of Dea Baltinore	ath	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 ☐ M 2 1 ☐ M	je (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Mir	n. (Month, Day,	Year) Co.	thplace (State or Foreign untry)
=	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation	Nov 10,	1935	MD 10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Worcester	Snow Hil				1 ¥ Yes 2 □ No
	ith the	a D	10e. Street and Number 207 W. Federal St.		10f. Zip Code 21863	1	0g. Citizen of What Co	Ť
	leath w	Funeral	11. Marital Status 12. Was Decedent I		/as Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - Ame	
980	s after o al", or Examin	d by	1 Never Married 2 Married Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	Yes, specify Cuban, Mexican, Pue ☐ Yes 2 ☐ No Specify:	no Hican, etc.)	Opcony.	rican-
Maryland 21215-0036	2 hours "natur edical I	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupation ind of work done during most of w	orking	16b. Kind of Business/	American Industry
2121	within 7 giene. er than the M		Elementary/Secondary (0-12) College (1-4 or 5	life DC	NOT use retired) Custodian	- I	Public Ed	ducation
pue	should be filed vand Mental Hyg rand Mental Hyg ramaric event,	To Be	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, M		ideacton
aryla	nd Mer mark maric		George A. Allen 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	Armatha g Address (Street and Number or F	a Collick	City or Town State Zin	Cadal
Ž,	nd 2 sh ealth a m 27 is ner trai		Inez Minor/daughter		Silver Court, Co			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place)	. (20c. Location - City or	
altir	permit. P Departme Importar any injur		21. Signature of Funeral Service Licensee	Ebenezer	UMC Cemetery 1/ Name and Address of Facility ewis N. Watson]	14/2012 Funeral II	Snow Hill,	MD
_	20 <u>7</u> 2		23a. Part 1. Enter the disease, or complications that caused		618 West Rd., Sa	alisbury,	<u>MD 21801 </u>	
	Physician/		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	the death. Do not enter	the mode of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a consequence of);	morrhage			78 days
		ner	Sequentially list conditions, if any least of the conditions cause. Enter Underlying	ranial ane	urysm			78 days
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09	ate be executed ohysician and the burial-transit	edical E	resulting in death) Last Due to (or as a	i consequence or):	J			
	rtificate ling phy e as th	/Med	IF FEMALE:					
Box 68	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	1 Ves 2 No 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del	very Day Year
О.	at the d d by the etacher		g Unknown 9 Unknown Part II. Other significant conditions contributing to death by	ut not application to the com-				
Records, P.O.	uires tha n signed ald be d	ed by	Tartin Outer Significant conditions continuiting to death by	at not resulting in the uni	denying cause given in Part I.	23e. Did toba	acco use contribute to s 2 X No 3 □ Pr	the cause of death? obably 4 Unknown
cord	law requ has beer je 2 shou	Completed				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Re	sician: The lav certificate has lirector, page 2		25. Was case referred to medical			perform 1 Yes 2		2 No
Vital	> 00	To Be	examiner?	ent 2 ER/Outpatient	26. Place of Death (Che		ce 6 Other (Speci	f _r)
Division of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending (Month, Day,	y 28b. Time of	28c. Injury at work?	28d. Describe how		
ISIO	Attendii er death. ector: Ai by the fu	Certificate:	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, stree	M 1 ☐ Yes 2 ☐ No et, factory, office		et and Number or Run	al Route Number,
2	pital or ours afte eral Dir filled in	Sal	building, etc			City or Town,		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical	29a. Certifier (Check only one) 2 Certifying Physician: To the best of received the best of examiner: On the basis of examiner on the basis of examiner. To the	amination and/or investig	ration in my opinion death occurred	l at the time date and	place and due to the c	auce/e) and manner stated
	Noth Com		001 01					
	E		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pri	29c. License number 4U4176435 Bro nt) St Baltimore, A	0552	01/04	10012
	ン)		Christopher Brown 22 31. Date filed (Month, Day, Year) 32 Justral	5 Greene S	It Baltimore,	ND 2120	Suite S	12-0
Ī	Stat Registra	200	JAN 11 2012 32. Fistral	's Signature	arles			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2012 11:34 a M Lillian Ann Tyree Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 577-30-3577 **Director** 1 M 2 🗓 F 85 Nov. 5, 1926 DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director be notified 1 X Yes 2 No Upper Marlboro Prince George's Maryland | 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral United States 20774 13002 Mears Court items permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) c than the M College (1-4 or 5+) Elementary/Secondary (0-12) Pastor Self-Employed ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental + 27 is marked of traumatic even မ Jeannette Thornton Benjamin Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 20708 7100 Scott Adam Court #101 Lisa Tyree - Daughter Laurel, Md. item 2 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 17, Department of Important: If it any injury or o 1 $\begin{tabular}{ll} \begin{tabular}{ll} \b$ 4 ☐ Donation 5 ☐ Other (Specify) 2012 Brentwood, Maryland Ft. Lincoln Signature of Franeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John Caylas Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final SEPSIS Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar and Due to (or as a consequence of): nding physician Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal uea ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ FAIWRE Division of Vital Records, RBNM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕏 Unknown Completed peen PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy BREAST performed Yes 2 METASTATIC CANCER After this certificate 2 🗌 No Yes • Hospital or Attending Physician: 7 24 hours after death. • Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of persor

UCK Road

ompleted cause of death (Item 23a) (Type, Print)

1-8-12

Lanham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Elizabeth Ε. Updyke January 8 2012 6:45P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3118 Gracefield Rd. Apt. CC-T07 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 213-56-7225 1 □ M 2 😿 F 90 12/4/1921 Usual Residence of Dece Washington, DC 10b. County 10c. City, Town or Location 10d. Inside City Limits |Maryland | Montgomery 1 Yes 2 X No Silver Spring 10e. Street and Number 10g. Citizen of What Country? 20904 3118 Gracefield Rd., Apt. CC-TO7 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giles F. Eubank Marion A. Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene U. Keighley/Daughter 10119 Silver Twine, Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1/10/2012 Edgewater, Maryland neral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 21. Signature Part 1. Enter the disease, or complication shock, or heart failure. List only one caus that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Fibrosis disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
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Physician/ Medical Examiner Examiner

signed by the attending physician and dbe detached for use as the burial-transit

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this certificate has

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within 24 hours after To the Funeral Direc

Physician/Medical

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Completed

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Certificate;

Medical

29a Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Department or Important: If any injury or once.

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f show

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er than "natural", or items 23a of the Medical Examiner must be

Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me

within 72 hours after death with

Baltimore, Maryland 21215-0036

notified at

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Funeral

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Sequentially list conditions if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Be. Did tobacco us	se contribute to the ca	use of death?
1 Yes 2	☐ No 3 ☐ Probably	4 🔀 Unknown
la. Was an autopsy performed?	24b. Were autopsy fi prior to comple death?	ndings available tion of cause of

1 Yes

25. Was case referred to medical examiner? 1 Yes 2 🗓 No 27. Manner of Death

Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at injury

2 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be determined

work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier nollew ender MA

29c. License numbe D0036716

29d. Date signed (Month, Day, Year) January 9, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kundrat, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904

State Registrar 31. Date filed (Month, Day, Year) JAN 1 0 2012 32. Registrar's Signature

DHMH 17 Rev 7/2009

-		Please Type or						-		_		
		State	of Marylan		artment d <i>rtificate</i> d			Mental Hy	giene	201	2 0222)
		Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rincate C	JI DE		2. Date of De	Reg. No ath	201	3. Time of Death	_
Physicia Medic		Julia Alman VanDemark						J ^{Month} Januar	y 18	š, 2012	5:20P. №	Λ
Examin		4a. Facility Name (if not institution, give street and num Sanctuary at Holy Cross	nber)		4b. City, Tow	vn, or Lo Surto	ocation of Death Onsville	2	40	. County of Dear Montgon	hery	
Funeral Director		5. Social Security Number 577-01-4150 6. Sex 1 □ M 2 🗓 F	7. Age (In yrs. Ia	ast birthday) 2 Yrs.	If Under 1 Y Months D		If Under 24 Hrs. Hours Min.	8. Date of Bir NOV • 2	th , 19 1	9. Bir S60	thplace (State or Foreign Tith) Carolin	
ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George		y, Town or Lo							10d. Inside City Limits	
vith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 13110 Greenmount Avenue	0 001	.00711	10f. Zip Co	705			10g. Cit	tizen of What Co	ountry?	0
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 1 □ Yes If Yes, Giv	е		Was Decedent If Yes, specify (Cuban,	eanic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify:		_
nin 72 hou ne. i han "natu e Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (9-12) College (1	-4 or 5+)	(Give	dent's Usual Oo kind of work do OO NOT use reti	one dun	on ing most of work	ding		ind of Business	Industry	
led witl Hygier other I ent, th	Be	17. Father's Name (First, Middle, Last)		NOA		1	8. Mother's Nam	ne (First, Middle,				_
d be fil Mental arked atic ev	P	John T. Alman	_			j	Lois E.	Pridmon	e	ourname)		
nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship (Type, Print) Barry W. VanDemark -sor	1	19b. Maili 13110	ng Address <i>(Str</i> O Green	reet and	Number or Rur nt Aveni	al Route Numbe ie Belts	r, City or S Vil	Town, State, Zip Le, Mary	land 20705)
. Page 1 a ment of H tant: If ite iury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)			osition (Name o matory or other an Crenat		1/17/	⁷ 2012		ocation - City or exandria	Town, State a, Virginia	I
permit Depart Impor any inj once.		21. Signature of Funeral Service Licensee		Ď	2. Name and Aconald V	ddress o	orgwardi	Funera	ıl He	ome, PA	yland 2070	_
		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on ea	aused the death	n. Do not ent	er the mode of	der dying, s	MT I Ro such as cardiac	or respiratory ar	SV1. rest,	lle, Mai	Approximate Interval Between	2
Physician/ Medical		Immediate Cause (Final disease or condition	ai lux	once of	2 4 pr		7				Onset and Death	
Examiner	e.	Sequentially list conditions, b	1,2209	Λ ΄	sepsi	7						
e executed sian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	or as a consequ	ence of):	Krick	777	K S I	rileo	520	my		
in ar e		resulting in death) Last Due to (or as a consequ	ence of):	-					-		
ificate ig phys as the	Medi	IF FEMALE:	-									_
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant 23c. If yes, out	come of pregnar Birth 2 Feta nant at time of d	Ideath 3	Ectopic preg					23d. Date of del Month	ivery Day Year	
uires that the signed by all the deta	by	Part II. Other significant conditions contributing to de	eath but not resu	ulting in the L	underlying caus	se given	in Part I.				the cause of death?	n
he law req te has bee age 2 shou	Completed						·	24a. Was autop	rmed?	prior to death?	copsy findings available completion of cause of	
sian: Ti ertificat ctor, p	Be C	25. Was case referred to medical examiner?			20	6. Place	e of Death (Chec		2 X NC	1 ∐ Yes	2 1340	
Physic this ce al dire	유	HOSPITAL:	Inpatient 2 🗆	ER/Outpatier	T 3 L DOA		4 Nursing Ho				ify)	_
eath. eath. or: After the funer	Certificate:		h, Day, Year)	injury	200.1	Injury at work? 1 □ Yes	s 2 🗆 No	28d. Describe h	ow injury	occurred		
ital or Atture after of ral Direct		4 Homicide determined 28e. Place buildin	of Injury - At hor ng, etc. <i>(Specify)</i>					City or Tow	n, State)		al Route Number,	
the Hosp nin 24 hor the Fune npleted fi	Medical	29a. Certifier (Check only one) 1	is of examination	and/or invest	tigation, in my o	pinion.	death occurred a	the time date a	nd place	and due to the o	ause(s) and manner state	.ed.
S Wiltim		29b. Signature and title of certifier		,	29c. Lic		umber 4 56 6		29d. Dat	e signed (Month	, Day, Year)	
17 W		30. Name and address of person who completed caus	e of death (Item	23a) (Type, F	Print) Silv	ren	eprin	of my) 2	0902		
State Registra			egistrar's Signati	ire				,				

 Birthplace (State or Foreign Country) Washington, DC 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian. Black. White, etc. White 16b. Kind of Business/Industry U.S. Government Mt. Airy, Maryland 21771 20c. Location - City or Town, State Frederick, Maryland Interval Between Onset and Death near 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month. Day. Year. Freene St, S9C16 Battimore MD. 21201

3. Time of Death

 P^{M}

9:59

2012

Carroll

Registrar DHMH 17 Rev 06-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

lurner MSCRNP

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year William David Waas January 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9800 Log House Court Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 11, 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Months Hours **Director** 219-48-9739 May Connecticut 61 Usual Residence of Decedent 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9800 Log House Court 20882 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1971-75 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ William Frank Waas, Jr. Virginia Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Waas - Wife 9800 Log House Court, Gaithersburg, Maryland 20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 【**Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematorium 1/13/12 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Funeral Service Licens ovest 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician**/ homa disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of: Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical use as yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27. Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pendina within 24 hours after death.

To the Funeral Director; At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D68925 PXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amv Kimball M.D. 22 South Greene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State JAN

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Margaret Woozley 2012 A M 2:00 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8 Date of Rirth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 90-24-6398 81 May 9, 1930 Pennsylvania Usual Residence of Decedent or 28a-f show with the Maryland must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a U.S.A. 7407 Willow Road 21701 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items. any injury or other traumatic event, the Medical Examiner musonce. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. δ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Edward Weber Edna Margaret Schreiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah W. Powell / Daughter 8107 Laurel Ridge Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombed cemetery, crematory or other place Resthaven Mem. Gardens 1-7-2012 Frederick, Maryland 22. Name and Address of Facility Robert E. Dailey & Son F.H., P.A. . Signature of Funeral Service Licenses 1201 North Market St., Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Rel Glood Cant comes wy to sove disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 21. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has bread director, page 2 s performed? death? Yes 2 completely filled in by the funeral director, 25. Was case referred to edical Be 26. Pl ce of Death @ eck only one) examiner? 2 **1** No Hospital 1 Tes Other: ၉ 1 Inpatient 2 I ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title prertifier 29c. License number 29d. Date signed (Month, Day, Year, D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline, MD 300 West Ninth Street, Frederick, MD 21701

Registrar

31. Date filed (Month, Day, Year)

JAN 10

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Man Physician/ Month 03 UD M Shir Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death now Baltimare 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral Director** 1 M 2 F 214-34-8502 75 11/26/1936 Kent Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 √ Yes 2 □ No MD Kent Worton 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 24891 Lambs Meadow Road 21678 USA items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. "natural", 3 Divorced Completed Specify: Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working if Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Stokes Dorsey Estella Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianelle Laney/Granddaughter 142 Hawkins DR Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State netery crematory or other plac Olive A M E ΜŤ 1/14/2012 Worton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home === 855 High ST Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lytra abdown Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or injury for use as the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month After this certificate has been signed by the struneral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 100 Other: ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural (Month, Day, Year) 5 Pending work Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 2

Registrar
DHMH 17 Rev 06-2011

Ms

State

reave St

Baltimore up 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

31. Date filed (Month, Day, Year)

PANT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Affend 21 per FH G924 2/3/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day/ Month Physician/ Medical 4a. Facility Name (not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P ster If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 □ F Hours 08/18/1926 PENNSYLVANIA Director 213-28-8842 84 Usual Residence of Decedent show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 737 ALDWORTH ROAD 21222 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE If Yes. Give 3 ☐XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DISHWASHER RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FLORENCE BRENNEMAN EDWARD WALLICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 ALDWORTH ROAD DUNDALK, MARYLAND 21222 PATRICIA LYNNE SCHOFF / NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 01/06/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 370 W. CYPRESS ST. MILLINGTON, MARYLAND 21 Jason Fellows per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between nset and D × h Immediate Cause (Final Physician/ disease or condition resulting in death) conce Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Recofds, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Yes 2 No a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Yes_ 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number mD. D0017036 1700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chartatown Mil 516 Was hong ton Ms

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registr

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jamuary 10°, 2012 0908 Wilson Charles D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Seventh Day Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 ☐ F Months Days Hours Min. Director Ärizona 67 527-60-6389 Jan Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland ral", or Items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Alexandria Virginia 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 22304 United States 5375 Duke Street # death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after Specify:African American 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Truck Driver Private Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked ofh
any injury or other traumotic filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Margaret Turner Samuel Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5375 Duke Street # 404 VA 22304 James E. Jackson - Friend Alexandria, 20a. Method of Disposition 20c. Location - City or Town, State 20h. Place of Disposition (Name of January 19 cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licensee 20019 Washington, DC 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy page death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 🔀 Inpatient 2 🗆 After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide work? injury 5 Pending Director: / Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hin 24 hours a the Funeral Γ Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie License number MD JAMUARY 10,2012 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNYEJIAKA 7325A HARIOVERPARKWAY GRECHBELT State Registrar

			_ State	Marylan		artment of				2	112	02236
P	4.1.7		Registrar 1. Decedent's Name (First, Middle, Last)		- 007	timeate of	Douth		2. Date of De	Reg. No. (_ ath	. O 1 E	3. Time of Death
	Physicia Medio	al	Roger Barmoy Walsh						Month	ry a	Year QUID	5:35 PM
	Examin	er	4a. Facility Name (if not institution, give street and number The Lions Center for Reha	b Ext	ere	4b. City, Town				4C. CO	ounty of Death	
, is	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Ye		er 24 Hrs. Min.	8. Date of Bir	:h	Llegany 9. Birth	place (State or Foreign
l.	Director		214-52-1647 Usual Residence of Decedent	64	Yrs.	ivionins Day	/s Hours		09-18-		Penn	sylvania
	and show	ō	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 93 Meshach Frost Village			10f. Zip Code	532			10g. Citizer	n of What Cour	ntry?
	teath w	Fune	11 Marital Status 12 Was Deceder	nt Ever in U.S	S. 13. \	Vas Decedent of Yes, specify Cu	f Hispanic O	rigin? (Spec	cify Yes or No-		Race - Americ	
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, Mai	and 2 should be Health and Ment tem 27 is marked other traumatic e		19a. Informant's Name/Relationship (Type, Print) Pamela Minnick daughte	er	19b. Mailir 10718	Mashin	et and Numb gton E	ber or Rural Hollov	Route Numbe Road	r, City or Tou Frost	on, State, Zip (D 21532
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ate Cum	Place of Dispo emetery cren berlan	sition (Name of natory or other p d Crema	tory	1-23-	ate -2012		tion - City or To erland,	
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Division of Vital	I or Atte after de Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I building,	Injury - At ho etc. (Specify,	me, farm, stre	et, factory, offic	е	2	8f. Location (S City or Tow		ımber or Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of 3 Certifying Nurse Practitioner: To	of examination	n and/or invest	igation, in my opi	inion, death c	occurred at t	the time, date a	nd place, and	d due to the car	use(s) and manner stated.
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	10 m		womerbefler			p	5055	325		Jan 2	-3,20	12
	Olu		30. Name and address of person who completed cause of	death (Item	23a) (Type, P	rint) Publish	$\alpha \Omega \alpha$	0 0	· who	da ml	mo -	u5()2
	Stat	е	31. Date filed (Month, Day, Year) 32. Regis JAN 3 0 2012	strar's Signat	ure		UNCL	w , C		WALL CIT	11100	(A)
	Registra	r	JAN J U ZUIZ Christ	p. 14	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Margarete Maria Aldrich 2. Date of Death Physician/ Month 2012 12:10 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** tor 8. Date of Birth 9. Birthplace (State or Foreign (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🗶 F Months Hours. 85 0 1 Morths Day 9277 Gestratery **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director traumatic event, the Medical Examiner must be notified Clarksville Montgomery Tennessee 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or United States of America Funera 213 Mills Drive 37042 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 X Married ģ "natural", or Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ Adalbert Heil Anna Margarete Krieg permit. Page 1 and 2 shoul Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Havre de Grace Marilland 21078 Elke Anthony (Daughter.) Foler Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Harford Mem Aberdeen Maryland Gardens 01/26/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home Signature of Funeration Washington S: Hauro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed Nasyew attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown 5 ☐ Other (specify) Pregnant at time of death detached 9 Unknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? io tne runerai Director: Atter this certificate has been signed completed filled in by the funeral director, page 2 should be del Completed by Records, Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autopsy performed 1 Yes 2 No To Be 25. Was care referre **Division of Vital** 26. Place of Deat (Check only one) examiner? 2 **N**o 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) and title of certifier 29b. Signat signed (Month, Day, Year) 30. Nat person who completed cause of death (Item 23a) (Type Print)

State Registrar

Margarete

Who

			. 101	of Maryland	d / Depa	artment of	Health an	id Mental Hy	giene		
			State Registrar		Cer	tificate of	Death		Reg. No. 2	012	02238
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month 01		Year	3. Time of Death
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	s 23a	era	7212 Piney Woods Place	2		20707	•	_	USA		
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36	after al", or xami	d by	If Yes, (s 2 🗶 No Give		☐ Yes 2X No				ecify: Bla	
ş	nours natura ical E	Completed	15. Decedent's Education		16a. Deced	ent's Usual Occup	oation		16b Kind	of Business/Inc	dustry
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g ∑	2 shoth and the and th		19a. Informant's Name/Relationship (Type, Print) Minnie W. Anderson/Wif					Rural Route Numbe			ode)
	I and f Heal item		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	:	Date Date		ion - City or To	wn, State
saltimore,	permit. Page 1. Department of I Important: If it any injury or or		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	nii Otate	-	natory or other pla Cemetery		/28/2012			
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VISION	Atten r deat ctor; by the	Tifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ce of Injury - At hom	ie, farm, stre		res 2 🗀 No	28f. Location (S	treet and Nu	ımber or Rural ı	Route Number
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	5 M M M		29b. Signatule and title of certiffer	100	0110	29c. Licens			29d. Date si	gned (Month, D	ay, Year)
•	10 m		30. Name and address of person who completed ca	JUU C	13a) (Timo Di	R1632	01		'//	1/12	
	1 0		Debrah Miller CRNP				ville.	MD 20850			
	Stat	е		legistrar's Signatur	8						
	Registra	ır	JAN 3 1 2012	men &	. ba	Med					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 26 Month Janet Gisriel Albright Ž012 5:09 P_{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center of Columbia Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗔 F Months Days Min (Moots,/34/1957 Maryland Maryland 217-58-6028 54 Director 28a-f show 10b. County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a 11612 Quarterfield Drive 21042 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceus. Armed Forces? Vas 2 XNo 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. ō 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Financial Analyst Finance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. ည William Gisriel **Dorothy Robinson** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Albright / Husband 11612 Quarterfield Drive, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 1/28/2012 Beltsville, MD 21. Signature of Funeral Service L 22. Name and Address of Facility **P**orota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Physician/ OVARIAN NE YEAR disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of Exami Due to (or as a consequence of) ding physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Just 12 months?

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9 ☐ Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ģ Pregnant at time of death Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe e Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate I ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Y Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tecriffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning the state of the 29a. Certifier completely

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year) JAN 3 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

29b. Signature and title of certifi

6336

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

CEDAR LANE COLUMBIA, MD 21044

JANUARY 26, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ onald ShTon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner och Raven Community Raltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month 103/1959 Country) Maryland 1 X M 2 L F Months Days Hours Min. 212-80-9927 52 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 337 Nicholson Road 21221 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No Army
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced White Year or Dates. 1977-83 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Manufacture Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Constance Marvin Richard Ashton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 337 Nicholson Road, Baltimore, MD 21221 Joan M. Ashton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 1/30/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death
Unknown 2 No as been signed by the a should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an prior to completio death? autopsy page performed 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be HUSDICE Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No after death. Investigation Accident the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 30 Name and address of person 2900 the completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

ack

2. Registrar's Signature

Please Type or Print in Black Indelib	le Ink. Ensure A	Il Copies Are Legible	0221							
State of Maryland / Department of Health and Mental Hygiene										
Certificate	e of Death	Reg. No.								
/iddle, Last)		2. Date of Death	3. Time of Death							

		1	For State of IVI State Registrar	aryiand / Dep Ce	artment of F rtificate of E			eg. No.		
	Disconinin		1. Decedent's Name (First, Middle, Last)				2. Date of Death	n Day Year	3. Time of Death	
3	Physicia Medic	al .	Robert Fra	ncis Andr			January	T	2:00 A M	
	Examin	er	4a. Facility Name (if not institution, give street and number) 4701 Willard Avenue, Apt.	822		Location of Death Chase		4c. County of Deat		
	Funeral Director		5. Social Security Number 6. Sex. 1 △ M 2 □ F 7. Ag	ge (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 18,	rth ay, Year) 8, 1921 Callifornia		
	ind show at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	<u> </u>			10d. Inside City Limits	
	Maryk 28a-f etified	irect	Maryland Montgomery	Chevy C	hase				1 ☐ Yes 2 💢 No	
	th the	Funeral Director	10e. Street and Number	011	10f. Zip Code	815		0g. Citizen of What Co United Sta		
	eath w	-une	4701 Willard Avenue, Apt. 11. Marital Status 12. Was Decedent		Was Decedent of H If Yes, specify Cuba			14. Race - Ame	rican Indian,	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. To it marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☒ Yes, Give Year or Dates.	No WWII	1 ☐ Yes 2 💢 No	Specify:	Rican, etc.)	Black, White Specify: Wh		
15-(72 hou n "nat Aedica	nple	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o OO NOT use retired)	ation during most of work		16b. Kind of Business United Sta		
212	within giene. er tha , the N		Elementary/Seconday (0-12) College (1-4 or 5	5+)	ign Servi			State Depa	rtment	
	should be filed with h and Mental Hygien 7 is marked other ti traumatic event, the	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam Louis		aiden Surname) nailly		
Maryland	ould b nd Mer mark imatic		Milton H. Andrew 19a. Informant's Name/Relationship (Type, Print)	19b Mail	ing Address (Street			City or Town, State, Zip	o Code) 20815	
	id 2 sh salth ar n 27 is er trau		Nicole R. Andrew / Wife	4701	Willard	Avenue, Ap	t. 822, Ch	evy Chase,	Maryland	
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposementary, cre Montgome Cremator	osition (Name of ematory or other place ry ium. Inc.	Janu 20	ary 30	20c. Location - City or Bethesda,		
Balt	permit. Departr Import. any inji		21. Signature of Fundal Service Licensee	Resear Re	22. Name and Addre	ss of Facility Tohrev Fune:	ral Home/E Bethesda, B	Sethesda-Chev Maryland 2081	y Chase, Inc. 4-3501	
d	Physician/		23a. Part 1/Inter the disease, or complications that cause shock or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition A121	ed the death. Do not ent ne. heimer's Di		g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death Years	
	Medical Examiner		and the state of t	a consequence of):						
		ner	Sequentially list conditions, b. Justo (or as cause. Enter Underlying	a ಕರ್ವಿಕರೆಗೆ ಬೆಗ್ಗೆ:						
	cate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events c			- ,	_ _			
_	oe exec ician a burial-t	al E	resulting in death) Last Due to (or as	a consequence of):						
3760	ficate figure g physas the		d	-						
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours atterded the contribicate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N		2 Fetal death 3 at time of death 5	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of de Month	livery Day Year	
s, P.O.	res that the signed by d be detacl	d by Ph	Part II. Other significant conditions contributing to death t	but not resulting in the	underlying cause gi	ven in Part I.		pacco use contribute to	o the cause of death?	
Records,	w requ	plete					24a. Was ar	24b, Were au	topsy findings available completion of cause of	
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ital	ician: certific ector,	Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No Hospital: 1 □ Input		Oth	lace of Death (Chec				
of V	g Phys er this eral dii	e: 10	27. Manner of Death 28a. Date of inju		of 28c. Injur	y at		ence 6 Other (Spec w injury occurred	cify)	
lon	ending eath. or: Afte	ficat	1 X Natural 5 ☐ Pending (Month, Date of the last of t	ay, Year) injury	M 1 🗆	Yes 2 No				
Division of Vital	ital or Att irs after d ral Direct led in by t	Medical Certificate:	4 Homicide determined 28e. Mace of in building, et	jury - At home, farm, st tc. (Specify)			City or Town			
	Hosp 24 hou Funer eted fill	edic	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inve	estigation, in my opini	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.	
	To the within To the comple	Σ	29b. Signature and title of certifier	500	29c. Licens			9d. Date signed (Mont		
	1/10) gur le	ill	D40	216		January 30), 2012	
_	13,10			625 Wiscon	ıs <mark>in Ave</mark> nu	ie, #101,	Bethesd	a, Marylan	d 20814	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr	rans Signature	7					

		•	1 - State Amend Items 25,27,28a-	laryland / De -f per me	epartment of Head g923,01727/2 Sertificate of Dea	alth and Menta 2012dhb ath	al Hygiene Reg. No. 2	2012 02242
г	Physicia	n/	Decedent's Name (First, Middle, Last)	~		2. Da	te of Death	3. Time of Death
-	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		1XLET 4b, City, Town, or Loc		140 CO	2012 20 58 PM
Programme State) LAAIIIII	CI	The Johns Hookins Hos	pital	Baltimos			N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 196-48-4559 1 ☒ M 2 ☐ F	ge (In yrs. last birthda 55 Yrs	Months Days H	ours Min. (Mo	te of Birth onth, Day, Year) 11, 1956	g. Birthplace (State or Foreign Country) Pennsylvania
	and show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits
	Maryl 28a-f notifie	Director	Pennsylvania Cumberland	Boiling	Springs			1 ☐ Yes 2 🔀 No
	ith the 23a or st be r		10e. Street and Number 11 S. Ridge Road		10f. Zip Code	7		n of What Country?
	leath w	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Specify Yes	s or No- 14.	Race - American Indian,
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	χ _{No}	1 ☐ Yes 2 XX No S			Black, White, etc. ecify: White
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212	within giene. er tha t, the I		Elementary/Secondary (0-12) College (1-4 or 2	5+)	and Surveyer		E	ngineering
Maryland	ld be filed Mental Hy arked oth atic evenl	To Be	17. Father's Name <i>(First, Middle, Last)</i> John K. Bixler, Jr.			Mother's Name (First, Dorothea E.		name)
, Mary	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	37	19a. Informant's Name/Relationship (Type, Print) Kathleen S. Bixler/ Wife		nailing Address (Street and last Ridge Road			
Baltimore,	Page 1 an lent of He ut: If item		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State 4 → Donation 5 → Other (Specify)	e cemetery,	isposition (Name of crematory or other place) n Cemetery	Date 1/6/ 12		tion - City or Town, State
Balti	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Funeral Service Licensee	110. 210	22. Name and Address of 5305 Harford R	Facility Leonard	J. Ruck, I	Inc.
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	d the death. Do not		· · · · · · · · · · · · · · · · · · ·		Approximate Interval Between
-1	h sician Medical	2	Immediate Cause (Final disease or condition	aabdo	minal	Hemorr	hage	Onset and Death
-	Examiner		Due to (or as	a consequence of):			J	
	ed nsit	Examiner	Sequentially list conditions, if any lead glock in rectain cause. Enter Underlying Cause (Disease or injury	a consequence of		CERTIFICATION APPROVE	- CU EXAMI	NER
	ate be executed hysician and the burial-transit	Exa	that initiated events c.	a consequence of):		LOPROVE	D BY WEDICHL	
09,	ate be ohysicia the bu	dical	d			CERTIFICATION AT		
Box 687	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transi	Completed by Physician/Me		2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)			d. Date of delivery Month Day Year
s, P.O.	ires that th signed by d be detac	d by Ph	Part II. Other significant conditions contributing to death	but not resulting in t	he underlying cause given i	in Part I. 23	Be. Did tobacco use	contribute to the cause of death? No 3 □ Probably 4 □ Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	omplete					autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a B	sician: The certificate irector, paç	Be C	25. Was case referred to medical examiner?		26. Place	of Death (Check only o	Yes 2 No	1 🗌 Yes 2 🗆 No
f Vit	Physic this ce ral dire	은				4 Nursing Home 5		
o uc	ttending death. stor: After y the fune	icate	The Natural 5 ☐ Pending (Month, De 2 X Accident _Investigation 12/12/2	av. Year) I iniu			escribe how injury or ject fell	
ivisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm tc. (Specify)	, street, factory, office	28f. Lo	cation (Street and N ty or Town, State)	umber or Bural Route Number, 331 E 01d Vork Pennsylvania 17013
	To the Hospital within 24 hours a To the Funeral t completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of	f my knowledge, de examination and/or ir	ath occurred at the time, da	ate and place, and due	to the cause(s) and	manner as stated.
	To the I within 2 To the I comple	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifying	ne best of my knowle	dge, death occurred at the ti			and manner as stated. iigned (Month, Day, Year)
ø			Shitteplu		· RES. 8	006	Janua	-y 2 2012
	(15)		30. Name and address of person who completed cause of ANTHONY TANNOU	S	pe, Print)			aryland 21287
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 7 2012	rar's Signature	backer			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Irene Bradsher 8:15PM January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BAUTIMORE NORTHWEST HOSPICE - SEASONS If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 202-18-7156 Director 1 □ M 2 🗶 F 89 07-02-1922 show 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a BATIMORE MD 1 ¥ Yes 2 □ No 10e. Street and Number ō 10g. Citizen of What Country? **Completed by Funeral** 2206 CECIL AVENUE 21218 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or i 1 ☑ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: BLACK 3 Divorced 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC ENGINEER event, the Be Baltimore, Maryland 18, Mother's Name (First, Middle, Maiden Surname)
SARAH Corus INS t of Health and Mental H

If item 27 is marked of

or other traumatic even 17. Father's Name (First, Middle, Last) မ PAUL BRAOSHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MITOHELL (SISTER) 2206 CECIL AVE. BALTO, MO. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or # 5 BAVINDEE, MD KING MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUSHN GREENE FUNDERSCIS Signature of Fundal Service Licensee YORK ROAD. BALTO, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END. Stage Demention Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by After this certificate has been signe funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Hospital or Attending Physician: The 24 hours after death.
Funeral Director, After this certificate I Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 - Nursing Home 5 - Residence 6 - Other specify to enth sup: 4 Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Funer completely fi

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State Registrar W

Sm in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2435

N-S Rajapakse Mil

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5203

00057465

29d. Date signed (Month, Day, Year) 1/28/12

Baldmore MD 21204

red Douglas B	ancı	1- For State Registrar	tate of Maryland	•	tificate of D		eniai my		eg. No. 201	2 0224
Physici Medical Exam		Decedent's Name (First, Midd Fred Douglas						2. Date of Death Month January 25		3. Time of Death 1228 hrs
vieuicai Exam	mer	4a. Facility Name (if not institution		er)	4b. C	City, Town, or Location		January 25	4c. County of Dea	
		Prince Georges Hosp		,		heverly			Prince Georg	
Funeral		5. Social Security Number		Age (In yrs. las		Under 1 Year If Under 1 Year If Under 1 Year			h(MM/DD/YYYY) 9. B	ian
Director		578-404180	1 M 2 F	79	Yrs.	ontris Days i Hot	urs IVIIII.	April	9 1932 c	ountry) DC
A TOTAL		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Location		-			10d. Inside City Limits
nd show a	7	MD Princ	e George's			Landover	Hills	3		1 X Yes 2 No
Maryland 28a-f sho d at ooce,	ecto	10e. Street and Number			10	f. Zip Code		10	g. Citizen of What Co	-
with the Maryland us 23a or 28a-f sho be ootified at occe,	II Dir		Avenue			207			USA	
ath wit tems 2 at be o	Funeral Director	11. Marital Status 1 Never Married 2 X M	12. Was Decede Armed Force	s?		cedent of Hispanic C pecify Cuban, Mexic			14. Race - Ame White, etc.	rican Indian, Black,
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215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "oatural", or items 23a or 28a-f ahe ent, the Medical Examiner must be ootfiled at oece	Completed	Elementary/Secondary (0-12)	ivate							
5-00; ed withi fygiene, other ti	Com	17. Father's Name (First, Middle	 , Last)			Carrier 18.Moth	ner's Name (F	First, Middle, M		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If iten 27 is marked other than iojury or other traumatic event, the Medica	P	19a. Informant's Name/Relations Yvonne V. Bake	e, Zip Code) MD 20784							
and 2 fealth attem 27 traum		20a. Method of Disposition	17 WIIC			(Name of cemetery,		Date	20c. Location - City o	
AOF ages 1 nt of F nt: If i		1 Burial 2 X Cremation			ematory or other p verdale C		1/30	/2012	Riverdale	, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If ites		4 Donation 5 Other S 21. Signature of Funeral Service	ins Funera ver, Maryl							
	9. 3	Daphney N.	. Corneliu	D						
Physician Wedical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			ode of dying, such as	s cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact Guns Due to (or as a cor							Death
		Sequentially list conditions,	b							
	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):						
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50, te be executed ysician and burial - transit	Medical	UNPENDED	dAMENDED							+
(D = 2 a)	Med	IF FEMALE:	23c. If yes, outo	come of pregna	ancy				23d. Date of deliver	у
Sox 6876 death certificat re attending phy 1 for use as the	jan/	23b. Was decedent pregnant in the past 12 months?	ne 1 Live birth	at time of deal	2 Fetal de		pic pregnanc	У	Month	Day Year
Box 687 (seath certifice) the attending place as the	Physician/N	1 Yes 2 No 9 Uni	known 9 Unknown		5 Other ((Specify)				
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Cord law rec has be 2 shou	Completed							autops	y prior to	completion of cause of
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of Vital Records, ng Physiciso: The law requir ufter this certificate has been s meral director, page 2 should i	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 🗸 E	ER/Outpatient 3	DOA Other		Home 5 P	Residence 6 Othe	er:
		27. Manner of Death	28a. Date of Ir (Month, Da) Jan 25, 201	njury 2 (Year)	28b. Time of Injury	28c. Injury at Wo	_ [0.	Bd. Describe ho	ow injury occurred	
	atio	1 Natural 5 Pend 2 Accident Inve	stigation		1150 hrs	1 Yes 2	No			
Division pital or Atteodion ours after death. eral Director: A	ertification:	dete	a not be	ingle Fami		ctory, office building,		or Town, Sta		ural Route Number, City
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To the Howithin 24 h	Medical	one) 2 Medical Exa	rniner:On the basis of ex and manner state	kamination and						
	ž	29b. Signature and title of certifie	er			29c, License numbe	er		29d. Date signed (Mo	
		00-(00	Co			O.C.M.E.			January 26, 201	2
le		 Name and address of person Ling Li, MD Assista 	who completed cause of ant Medical Examin	,	•	treet, Baltimore,	, MD 2122	23		
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	ì	Physicia Medic		1. Decedent's Name	e (First, Middle V . Bı									2. Date of De Januar		26 , 20	o 1°2″	3. Time of E	Death PM
(Examin		4a. Facility Name (if Stella		n, give street and nu	mber)				Town, or		of Death				of Death		
		Funeral Director		5. Social Security N 213–26–3	umber 497	6. Sex 1 M 2 F	7. Age	Age (In yrs. last birthday) 94 Yrs. 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				8. Date of Birth 9. Bi			9. Birth Cour	place (State or	Foreign		
		and show at	or	Usual Residence of 10a. State	of Decedent 10b. County			10c. City	, Town or	ocation								10d. Inside City	Limits
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р.ш.	36	is filed within 72 hours after death with the Maryland tal Hyglene. 3d oth Hyglene and "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	11. Marital Status 1 Never Marr 3 XWidowed		If Voc C	orces? 2 🔀 I ive		. 10	B. Was Deced If Yes, spec				ecify Yes or No- Rican, etc.)	-		ck, White,		
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JANUARY	Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		20a. Method of Disp 1 XBurial 2 4 Donation	☐ Cremation	3 ☐ Removal from	m State	Oak	ace of Dis Enetery, ci Lawn	position (Nar rematory or c Cemet	ne of ther plac Ery	ce)		Date 30 ,2 012			- City or T	own, State yland	
JANI	Balti	permit. Departr Importa any inju		21. Signature of Fu	neral Service I	Licensee M= +ax	4.1.4			22. Name ar	d Addre	ss of Faci	lity gel an	d Cremat ville.Ma	ian s	Servjo	es Es		
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	Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown	months? 【 No	23c. If yes, or 1 ☐ Liv 4 ☐ Pre 9 ☐ Un	e Birth gnant at		I death 3	Ectopic Other (s)		су				i	ate of deliv	ery Day Ye	ear
BUSKE	s, P.O.	res that the dea signed by the a d be detached f	by	Part II. Other signif	ficant conditi	ons contributing to	death b	ut not resu	ulting in the	e underlying	cause giv	ven in Par	t I.			o use cont		he cause of dea	
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	ш	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical	(Check 2	Medical I	g Physician: To the Examiner: On the b g Nurse Practition	asis of ex	kamination	and/or inv	estigation, in	my opinio	on, death	occurred at	t the time, date	and pla	ce, and du	ie to the ca	iuse(s) and mani	ner stated
		To the within 2 To the comple	2	29b. Signature and		10/0/1	NP	55050 0111	ly Knowled			e number	797	abe, and due to			(Month,	Day, Year)	
1		7		30. Name and addr	ι						7	1 (116		100	1011			
)		Stat	te	JACKIE 31. Date filed (Mont		CRNP 23	Negistra	r's Signati	ure .	ALLEY	KD.	TIM	ONTO	M, MD 2	109	3			
of	l.,	Registra	ar		IAN 3 1	2012	ann	م ب	1. 4	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 27, 2012 James E. Blackiston, III 10:46 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 XM 2 □ F Days Hours Min OCE. 17 Year 938 Mary land Months 73 219-34-7054 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Liberty Court 21040 United States 12. Was Decedent Ever in 1961 – Armed Forces? 1 ☑ Yes 2 ☐ No 1964 If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: nan "natural", o Medical Exam 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d 2 should be filed within 72 aith and Mental Hygiene.
127 is marked other than "rer traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** United StatesArmy Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosalie Oleita Davis James E. Blackiston, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Blackiston / Wife 413 Liberty Court Edgewood, Maryland 21040 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Dat 31. Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bel Air, Maryland 21. Signatur of Funeral Service Licens 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
Report Hill Maryland 21050 Newport Drive Forest Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final ot Ph_sician/ eus disease or condition resulting in death) DREU Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or liniury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death been signed by the s a | Linknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Herra to che zia 1 ☐ Yes 2 🗷 No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has retastatio Susperted disease 1 ☐ Yes 2 ☐ No ivision of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဂ္ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse practices to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse practices to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) January 27, 2011 DO053568 ssof person who completed cause of death (Item 23a) (Type, Print) 500 UPPC Chesapeake 10 Maryland HOMPSON MD Bel Air 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY g923 1/31/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 24 Rickey Bullock Physician/ January 2: 26 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1909 Harlem Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 217-84-5683 **Director** 1 XM 2 F 47 03-20-64 Yrs MD Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral USA 1911 W. Lanvale Street permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. African Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Marriott Hotel life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chef B.W.I. 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Bullock Mildred Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rickey & Shanita Bullock 2820 Belmont Avenue Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-31-12 Randallstown, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line END-Stage Cardion yopathu Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed' Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? sister;s residence Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Askajapathem.n 00057465 1/26/12

DHMH 17 Rev 06-2011

State Registrar Smion AV

5703

Balhmore MD 21709

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N-S-RAUPAKK, M.D. 31. Date filed (Month, Day, Year)

2835

Pt Known AS: Bradby, Alther Baltimore, Maryland 21215-0036

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			For State Registrar	State of Maryla		artment of r tificate of L		мента пу	Reg. No	21117	02248	
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an Albana	Medic Examin	al	4a. Eacility Name (if not institution, give	R •	~	Bradby 4b. City, Town, o	r Location of Dea	th <u> </u>	-)	County of Death	7,011	
ممسروه			5. Social Security Number 6.5	1 0 0011	more	Ball If Under 1 Year	If Under 24 Hrs	City 8. Date of Bi	eth.	th 9. Birthplace (State or Foreign		
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	ith the Mi 3a or 28 t be notii	ral Dire	10e. Street and Number 1121 St. Agnes	Lane #220	· · · · · · · · · · · · · · · · · · ·	10f. Zip Code	L207		10g. Ci	tizen of What Cou	ntry?	
396	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	-	14. Race - Americ Black, White,	can Indian,	
21215-0036	ithin 72 hours ene. • than "natur he Medical I	Completed	15. Decedent's I (Specify only highest g. Lementary/Seconday (0-12)	ducation	(Give I	lent's Usual Occup kind of work done of NOT use retired)	during most of wo	· ·		ind of Business In Niversit	-	
	oe filed within artal Hygiene.	To Be	17. Father's Name (First, Middle, Last) Robert Randall	Surname)								
Maryland	12 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Delma Bennett-					r Town, State, Zip				
Baltimore,	Page 1 and 2 s nent of Health int: If item 27 iny or other tra		20a. Method of Disposition 1 💢 Burial 2 🗌 Cremation 3 🖂 4 🗋 Donation 5 🖂 Other (Spec	Removal from State		sition (Name of natory or other place Forest		Date /2012	1	ocation - City or T		
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Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director. After completed filled in by the funer	Certificate:	2	De 28e Place of Injuny - At			i les Z 🗆 No	28f. Location City or To		nd Number or Rura e)	al Route Number,	
	e Hospita 24 hours e Funeral	Medical	(Check 2 L Medical Exam	ysician: To the best of my kno niner: On the basis of examinat rse Practioner: To the best of	ion and/or inves	tigation, in my opini	on, death occurred	d at the time, date	and place	e, and due to the ca	ause(s) and manner stated.	
	To the within comp	-	29b. Signature and title of certifier	7)0	29c. Licens		50	29d. Da	ate signed (Month,	Day, Year)	
2	V		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, F	Print) 5	inai t	tes pit	er_/	of Ba	28,2012 Himare	
	Sta Registra		31. Date filed (Month Day Year) JAN 3 1 2012	32. Registrar's Sign	nature				√			

12-00736

Kevin Chandler Bryant

Please T	ype or Print in	Black li	ndelible li	nk. Ens	ure All	Copies	Are Leg
	State of Marylar	d / Depa	artment o	f Health	and Me	ntal Hyg	iene

in Black Indelible ink. Ensure All Copies Are Legible.			
land / Department of Health and Mental Hygiene	20	12	02249

		1- For State Certificate of Death Reg. No.										
Physicia	_	1. Decedent's Name (First, Middl	e,Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
Aedical Exami		Kevin Chandler H	Bryant					January	25, 2012	102)	1708 hrs	
		4a. Facility Name (if not institutio		mber)	4	b. City, Town, or Lo	ocation of De	eath		unty of Death	n	
		8106 Wood Point Place	се			Ellicott City			How	ard		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of E	irth (MM/DD/)			
Director		412 63 3511			V	Months Days	Hours	Min.		Foreig		
	Ļ		1 M 2 F	24	Yrs.			Februa	ry 26,19	987 Nasi	oville TN.	
b	ŀ	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Location	nn .					10d. Inside City Limits	
w any											1 Yes 2 No	
and sho	5	MAryland Howai	rd	E	llicott (44	
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?	
the N	高	8106 Wood Point	: Place			21043			United	States		
0036 within 72 hours after death with the Maryland jene. ter than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	ē	11. Marital Status		edent Ever in U.S		Decedent of Hispa					ican Indian, Black,	
eath item	Funeral	1 Never Married 2 M	arried Armed Fo	orces?	lf Ye	es, specify Cuban, I	Mexican, Pu	erto Rican, etc.)		White, etc.		
ter d		3 Widowed 4 Div	Spe	ecity: Whit	te							
rs af	ğ	15. Decedent's Education (Spe	or Dates: cify only highest grad	ie completed)		's Usual Occupatio			16b. Kind	of Business/	Industry	
5-0036 led within 72 hours afte Hygione. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during mo	st of working life. D	OO NOT use	retired)				
36 hin 72 then edical	롈		2		Stud	ent			Sta	ıdent		
Sein with	5	17. Father's Name (First, Middle,	Last)		Ocud	16	3.Mother's Na	ame (First, Middle				
File H E 4	Be	Warren Edward Bry				i		eth Chandl				
21215-0036 2uld be filed within 7 I Mental Hygiene, I marked other than is event, the Medica	9	19a. Informant's Name/Relations		-	19h Mailing	Address (Street				r Town. State	a. Zip Code)	
S chou	-	Warren Edward Bryar			1	,						
≥ g d a i		20a, Method of Disposition	it/raulei	20h F		ood Point I		Date Date			Town, State	
s la		1 Burial 2 Cremation	3 Removal fro		rematory or oth		31317,	Buto	200. 200	O, o	, 5	
Page ent o		4 Donation 5 Other S			11 awn Merr	orial Park		/31/2012		rille,T		
Baltimore, permit. Pages 1 at Department of Her Important: Wite injury or other tr	ı	21. Signature of Funeral Service		1.50	22. N	ame and Address of	of FacilityBut	roee Henss	Seitz F	uneral	Hôme Inc	
E P P E		MIDL M	West		363	1 Falls Roa	ad Balti	imore Marv	land 212	711	none inc.	
Physician	一	23a. Part I. Enter the disease, or		aused the death.	Do not enter th	e mode of dying, s	uch as cardi	ac or respiratory a	rrest, shock,	or heart	Approximate Interval	
/Medical	3 2	failure. List only one cause	NT	a Intov	iontion						Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of							3	
		TARREST TO STATE OF THE STATE O	h		,-							
	5	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	·):							
	딑	cause. Enter Underlying Cause (Disease or injury that initiated	c									
	Examiner	events resulting in death) Last	Due to (or as a	consequence of):							
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e exe	Physician/Medical	X UNPENDED	AMENDED 2	23a,27,2	8a-f,pe	r me,g92	4 2-3-	-12 sm				
760, ficate be g physic the bur	Š	IF FEMALE:		outcome of pregr	nancy				23d. Da	ate of deliver	У	
rtific rtific ling p	an/	23b. Was decedent pregnant in the past 12 months?	I I LIVE D	pirth		al death 3	Ectopic pre	egnancy	Moi	nth	Day Year	
Box 68 e death certifuther attending ed for use as	2		lem autom	ant at time of de	ath 5 Oth	ner (Specify)						
Box 687 ne death certifi the attending	Ě		3 OIININ					100 0			the course of deaths	
that the ned by detache		Part II. Other significant condit	tions contributing to	death but not re	sulting in the u	nderlying cause giv	ven in Part I.				the cause of death?	
res the signe	d by							_ [1_]Y	es 2 No	o 3 Pro	bably 4 🗹 Unknown	
ords, w requir s been s should	Completed							24a. Wa	is an 2 opsy		utopsy findings available completion of cause of	
SO law has las 2 sh	핕				-			per	formed?	death?		
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tal Rection: The certificate ector, page	B	25. Was case referred to medica examiner?	Illeveltet.					eck only one)	7			
this dire	P	1 ✓ Yes 2 No	· L · · · · ·	Inpatient 2	ER/Outpatient			ursing Home 5			er; Scene	
ing Ph After t		27. Manner of Death	28a. Date (Month	of Injury ı, Day,Year)	28b. Time of I		at Work?		e how injury o			
ion tendi	읥	1 Natural 5 Pen-	ding estigation fd 1	-25-12	fd 17:00) 1 Ye	es 2 X No	subjec	ct tool	k arug		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:					et, factory, office bu	ilding, etc.	28f. Location	(Street and I	Number or R	ural Route Number, City	
Divi pital or ours after ours after	eri	4 Homicide determined (Specify) residence Ellicott City, Md.										
Yosp 4 hou Puner		29a. Certifier 1 Continue Physician. To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		miner:On the basis	of examination a								
No No No No No No No No No No No No No N	Mec	29b. Signature and title of certific	and manner s er	stated		29c. License	number		29d. Date	e signed (Mo	onth, Day, Year)	
		0	al lond)		O.C.M	1.E.		Januar	ry 26, 201	2	
		laid	Mull	ou								
7		30. Name and address of person				imara Ctt	Daltim	MD 24222				
8			sistant Medical			miore street, i	ракшиоге	, IVID 2 1223				
	tate trar	31. Date filed (Month, Day Year)	32. R	egistrar's Signatu	artis							
	1 4-14	OWIL O T TALE	Mount	14. 14	COLPS John							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAN ROBERT BAILEY 2012 4:50a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Hours 226-46-2874 **Director** 75 1 🕱 M 2 🗆 F Feb. 11, 1936 VΔ Usual Residence of Decedent 28a-f show 10c. City, Town or Location with the Maryland must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2 X No MD Prince Georges Clinton 10e. Street and Numbe õ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6811 Groveton Dr. 20735 USA death \ 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. or 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. 'natural", Specify. 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 8th Crew Chief WSSC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Daniel Bailey Helen Hunt 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Important: If item 27 is a any injury or other traunonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6811 Groveton Dr. Shirley Bailey - Wife Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 2-1-2012 Laurel, MD 21. Signature of Foneral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitlnad Rd. Suitland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, i i n MUSSIVE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or to a consequence or): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for Month Day 5 Other (specify) Pregnant at time of death Yes 2 No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 110 ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work' Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, A filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signature and title of certifie

JAN 3

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

1 2012

29d. Date signed (Month, Day, Year)

01/20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 2924 2-3-12 vt.

			For State Registrar	State of Marylan		ificate of E			Reg. No	201	2 0	225
	Physicia		1. Decedent's Name (First, Middle, Las EDWARD E. BOND, II	•				2. Date of Dea Month	Da		3. Time of 4:40	Death A M
	Medic Examin	al	4a. Facility Name (if not institution, give		Т	4b. City, Town, or	Location of Deat	<u> JANUARY</u>		. County of Death		
بسميه	,		STELLA MARIS			TIMONIUM	If Under 24 Hrs			BALTIMORE		-
	Funeral Director	- 1	5. Social Security Number 6. Sec. 1	ex ☐X M 2 ☐ F 79	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		y, Year)	9. Birth Cour	place (State ontry) MD	or Foreign
	3		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loca	ation					10d. Inside C	ity Limits
	farylan Ba-f sh Lified a	ecto	MD BALTIMOR		ONIUM						1 🗆 Yes	2 X No
	h the M a or 28 be not	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Cou	intry?	
	ath witl	nner	2300 DULANEY VALLE	EY RD 12. Was Decedent Ever in U.S	S. 13. W	21093 as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	USA	14 Race - Ameri	can Indian,	
215-0036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ★ Yes 2 → No If Yes, Give Year or Dates.		Yes, specify Cuba		to Rican, etc.)		Black, White,	HITE	
15-(72 hou in "nati Medica	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give ki	ent's Usual Occup nd of work done o NOT use retired)	ation <i>luring most of w</i> o	orking	16b. F	Kind of Business In	ndustry	
™. 212	led within I Hygiene. other tha ent, the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	ELECTR	CICAL ENG			Ļ	STEEL COM	IPANY	
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4:40 Maryl	2 should Ith and Me 27 is mar r traumati	0.000	19a. Informant's Name/Relationship (T) STEVEN BOND-SON	ype, Print)	1	JEROME J				r Town, State, Zip LLE, MD 2		
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Specie	Removal from State	Place of Dispos emetery, crem		e) 2	Date 2/12		Location - City or T		
Baltiı	permit. Pag Department Important: any injury c		21. Signature of Funeral Service Licens	1 - 1 - 1	22.		ss of Facility M	ILLER-DI	PPEI	FUNERAL MD 21206	HOME,	INC
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	pications that caused the deat e cause on each line.	h. Do not enter	the mode of dyin	g, such as cardia	c or respiratory ar			Approxima Interval Be	tween
	Ph_i_ian/ Medical	ŭ ĝ	Immediate Cause (Final disease or condition resulting in death)	a. END	STAG	E DEN	ENTI	A			Onset and	eath V.S
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43	cate be executed physician and the burial-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):							
ARY 760	te be e hysicia he buri	edical		d			<u> </u>	<u> </u>				
JANUARY Box 68760		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnation 1 Live Birth 2 Fett Fett Pregnant at time of 9 Unknown	al death 3	Ectopic pregnand Other (specify)	ру			23d. Date of deli Month		Year
. P.O.	es that the signed by I be detac	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the ur	nderlying cause gi	ven in Part I.	- 1		use contribute to		
1.1 ords	w requii s been should	Completed				·		24a. Was		24b. Were aut	opsy findings	available
Recoi	The lav ate has page 2	Somy						auto perfo	ormed?	death?	2 🗆 No	
BOND Vital F	sician: certific rector,	B	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Oth	er: (Ch			s Пон (5)		
EDWARD BOND 111 Division of Vital Records.	ding Phys th. After this funeral di	cate: To	27. Manner of Death Natural 5 Pending 2 Accident Investigatio	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	y at	28d. Describe		6 Other (Special of Control of Co	ту)	
E DW	l or Atten after dea Director: d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	De 290 Place of Injuny - At he		et, factory, office		28f. Location (City or Tox		nd Number or Rur e)	al Route Num	ber,
	ne Hospita n 24 hours ne Funeral	Medical	(Check 2 Medical Evan	rsician: To the best of my know tiner: On the basis of examinationse Practioner: To the best of m	n and/or invest	igation, in my opini	on, death occurred	d at the time. date :	and plac	e, and due to the c	:ause(s) and m	anner stated.
4	To the vithin comp		29b. Signature and title of certifier	Preis CRH		29c. Licens			29d. D	ate signed (Month)	, Day, Year)	
	5×1		30. Name and address of person who			rint) VALLEY	ROAD TI	MONIUM,	MD	21093		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 1 2012	32. Registrar's Signa	Sark							

Angela C. Biggins

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	State of Maryland / Department of Health and Mental Hygier	ne

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	1	1- For State Registrar				Certificate of Death						Reg. No.					
Physicia Medica! Examin	-	1. Decedent's Name Angela	ins							2. Date of Death Month Day Year January 17, 2012 3. Time of Death 2114 hrs							
Wedical Examin		4a. Facility Name (i									anuary 17	4c. County of Death			171113		
		Baltimore W	/ashingtor	nter	Glen Burnie							Anne Arundel					
Funeral Director		5. Social Security N 354-54-		n yrs. last bir 35	Advantage Day of Harris Adia					8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) IL							
		Usual Residence of Decedent															
ow any	1	10a. State 10b. County 10c. City, Town or Location 10d. Inside City L 1 10d. Inside City L 10d. I															
uyland ia-f show it once.	홠	10e. Street and Number					10f. Zip Code					10	10g. Citizen of What Country?				
	Il Director	7129 S. Harding					60629						USA				
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces?						 Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric 					14	Race - Ame White, etc.	ce - American Indian, Black, iite, etc.		
ufter de	ð.	3 Widowed 4 Over the state of t						1 Yes 2 XXNo specify:					Specify: White				
hours a	팋	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired										16b. Kind of Business/Industry					
17215-0036 Id be filed within 72 hours after featal Hygiene. Barked other than "matural?" event, the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)						Job Recruiter					Recruiting				
5-00 led with the strain of the Merican strain of the stra	ᆰ	17. Father's Name (First, Middle, Last)						3.Mother's Na	er's Name (First, Middle, Maiden Surnan								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	å	Timothy Mullaney Rosemar										-	Petsco				
Baltimore, MD 21215-30; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: Witem 27 is marked other timportant: Witem 27 is marked other thinjury or other traumatic event, the Mediumy or other traumatic event, the Medium 30 is supported to the supported and 30 is supported and 30 i	٢	19a. Informant's Name/Relationship (Type, Print) Rosemarie Jasik Rosemary Jasik Mother 7129 S. Harding,										nicago				ode)	
ore, ss l and of Heal If iten	1	20a. Method of Disp 1 Burial 2		3 X Remov	al from State		tory or other	er place)				6/12	20c. Location - City or Town, State				
Baltimore, permit. Pages 1 a Department of He Important: If ite	Į.	4 Donation 5 Other Specify: WOOdLawn Crematory ''								-			Forest Park IL				
Balti permit. Departm Importa	Ţ	21. Signature of Full	neral Service	Vi	ctor P	. Doda	* 'Ch	arles	EO	Steve	ns]	Funera , Balt	l Ho	me, In	C 2123		
Physician	7	23a, Part I. Enter th			at caused the	death. Do n									Appr	roximate Interval ween Onset and	
/Medical Examiner		Immediate Cause (I	rinal disease	a. Multiple Injuries Death													
71	-	or condition resulting		Due to (or a	as a consequ	ence of);											
	<u>ĕ</u>	Sequentially list cor if any, leading to im cause. Enter Unde	mediate		as a consequ	ence of):											
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x 6876 h certificat tending phy use as the	- 14	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy									Month Day Year						
Box 68760, death certificate be attending physic of for use as the burner.	Physiciar	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown															
P.O. B. that the de need by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										Did tobacco use contribute to the cause of death?					
S, P. Lires th	ed by																
ion of Vital Records, P.O. I tending Physician: The law requires that the eath. ior: After this certificate has been signed by the funeral director, page 2 should be detached.	Completed									_	24a. Was an autopsy findings a prior to completion of ca death?						
tal Rec	5											1 Yes 2 No 1 Yes 2			2 No		
Vital ysician: his certifi director,	8	25. Was case referred to medical examiner? 1. Was 2. No.										nty one) Home 5 Residence 6 Other:					
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tion ttendii death.	<u></u>	1 Natural 2 ✓ Accident	5 Pend Inves	ling Jan`	2 hrs	s 1 Yes 2 ✓ No Di				river auto auto collision							
Division sapital or Attendin hours after death. Increal Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specific) Major Pood (Altistructure)								St. Location (Street and Number or Rural Route Number, City or Town, State) Ref. 3 North of Waugh Chapel Dr., Crofton, MD							
DIV the Hospital or hin 24 hours afte the Funeral Div	ဒ္ဓ	4 Homicae Major Road / Fighway														ION, MID	
Division of ¹ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated and manner stated															
H S H S	žΪ	9b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)				y, Year)			
	30. Name and address of person who completed cause of death (Item 23a)									January 18, 2012							
0		 Name and address Carol Allan, 		who completed on sistant Medic		, ,	W. Balti	more S	treet, B	Baltimore,	MD 2	1223					
	_	31. Date filed (Mont.	h, Day Year)	32	. Registrar's	Signature						_				-	
Registr	ar	JAN 3	2012	Chause	1.	Mark											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 12:09 P M Brooks 2012 Marguerite Frances January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Months **Director** 213-03-5273 1 □ M 2 🗓 F 06/11/1918 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2X No MD Anne Arundel Linthicum 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 304 Homewood Road 21090 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) MD Yacht Club Hostess 8 yrs. permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dora White Alexander Vesper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 304 Homewood Road Linthicum, MD Mr. Wayne R. Brooks / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 02/01/2012 | Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Approximate Interval Between nset and Death Immediate Cause (Final Ph_{sician}/ 0 C disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 And 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 - No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending ours after death. eral Director: Aft filled in by the fur Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month, Day, Year) 2001 January 27, 2012

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of

31. Date filed (Month, Day, Year)

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se of death (Item 23a) (Type, Print)

32. Registrar's Signature

who completed cap

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 1 Month 24^{Day} Physician/ 2012 Alma Alice Brown 1:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4800 Seton Dr. N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9-10-797 Min. 1 ☐ M 2 ☐**X** Months Hours 1 272071922 Maryland 89 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4800 Seton Dr. 21215 U.S.A 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married Yes 2 X No Completed by 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes. Give Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) 8th Grade Pet Groomer Unk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Norman Brown Louise Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Curtis(niece) 3802 Bartwood Rd., Baltimore, MD 21215 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) on-site Crematory (1) 4617 Baltimore, MD Signature of Euneral Service License Jóseph Addess of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Common disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury hemolial Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a g 🗌 Unknown 9 Unknown P.O. 1 s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number avva 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sto A(I3 A + HAStom I MD, 82(N St Sinte 308 BALTIMORE MD 2120 BUTAW

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Amend Item 25 per me, g923,01/27/2012dhb 19bper FH

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Blondell Physician/ Clay Month 14:55 PM anuary 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital of Baltimor Baltimore City 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min Hours Director 1 🗆 M 2 💢 F SC 08 1937 11 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Randallstown Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 3801 Schnaper 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian th and Mental Hygiene.
77 is marked other than "natural", or itel traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Benefits Social Security year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Ulusses Anna Jones 19a. Informant's Name/Rela onship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Alma Gray 3531 Sea Pines Curtcircle Randallstown MD 21133 (Sister 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
King Memoria | Park Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Window Mill, MD Ol C. GREETE FUNERAL Services . Signature of Funeral Service License Vailann Road Randallstown MD 21133 Libertu disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. 23a. Part 1. Enter the shock, or heart Approximate Interval Between Onset and Death Immediate Cau Portraces ileal - Physician disease or condition Medical resulting in death) 4 days **Examiner** Sequentially list conditions Examine Due to for as a por secular neith If any, leading to immediate cause. Enter Underlying APPROVED BY INEDICAL EXAMINER burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Dav Year been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Was an autopsy performed?
Yes 2 1 Nc has page 2 certificate 2 🗌 No 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitionar To the best of my knowledge, death on of all the Boar 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A.V. Lam Krmas RES-000 January 21 2012

State Registrar Sinai Hospital of Ballimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS

2. Registrar's Signature

Dr. Venkata Angirekula

JAN 2 7 2012

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month O 0105AM rincetta Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Baltimore C Baltimore, Samartan HOSPITO If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 06 -02 - 1934 Birthplace (State or Foreign Country) cial Security Number 7. Age (In yrs. last birthday) **Funeral** Months NC **Director** Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director BAUTIMORE 1X Yes 2 No 10g. Citizen of What Country? Funeral 315+ STREET US 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 9 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates BUACK Completed 3 - Widowed 4 Divorced er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CROSS KEYS COOK Department of Health and Mental Hygiei Important: If item 27 is marked other tany injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JONES KUTH LIGON DILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ArNHEM Rd. BALTO MD. 21206 DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State BATTIMORE, MD 2/4/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VANGHN GREENE FUNERALSIS ROAD. BALTO, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause proeach line. Approximate rval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and ending physician use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery ned by the atter in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate has ral director, page 2: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of D ath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural

Natural

Accident

Suicide

Homicide injury 5 \square Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 📈 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gerpfying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Sign 01-27-2012 samaritan Hospital EHERGENCY Department Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ G1enna Ď. Cave 2012 12:36 January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1124 Newfield Road Gwynn Oak . Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 219-28-9851 **Director** 1 🗆 M 2 🗶 F 99 APR 27, 1912 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No MD Baltimore Gwynn Oak 10e. Street and Number ò 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? Funeral 1124 Newfield Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin. life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4 or 5+) Foster Parent Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Dadds Virginia Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Cave, son 1716 Carroll Avenue Halethorpe, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory, Inc. 01/30/12 Baltimore, MD George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. EMOTH 299 Frederick Road Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as a consequence of Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No Yes the Hospital or Attending Physician: Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death, E Funeral Director: After i letely filled in by the funer 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State

101

Suite 275

700 Geipe Rd.,

or person who completed cause of death (Item 23a) (Type, Print)

M.D.

St.Martin,

Janaury 30, 2012

21228

Catonsville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carol Francis Carter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day January 28, 2012 1400 hrs **Medical Examiner** Carol Frances Carter 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 11409 July Drive # 402 Silver Spring 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Foreign Months Days Hours Director Country New York 095-42-2131 1 M 2 X F Yrs 1950 62 JAN 18 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location Yes 2 X No Silver Spring Montgomery hours after death with the Maryland rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20904 Ö 11409 July Drive, Apt. USA 23a noti 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 2 X No Yes Specify: Black 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.

If item 27 is marked other than " Baltimore, MD 21215-0036 Sales / Floor Manager Department Store 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unk. Alfred Chester Frances 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ Fresh Meadows, NY 11 365 10C 71st Crescent Cherisse K. Carter, daughter | 118 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 02/02/12 Baltimore, MD rtment Metro Crematory, Inc. Donation 5 Other Specify Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical $x_{AMENDED}$ # 1 as noted, 19b, 23a, 27, 28a-f, per me, g925 3-19-12 sm X UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) y the at 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? Yes 2 No After this certificate 1 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 ٩ 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 Natural subject assaulted 1 Yes 2 X No fd 01-28-12 fd 1430 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11409 July Dr. #402 Silver Spring, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 ___ Could not be Suicide Residence 4 Homicide determined 29a. Certifier 1 ___ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E January 29, 2012 30. Name and address of person who comp leted cause of sath (Item 231 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 32. Registrar Signatu State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

DHMH 17 Rev 06-2011

Suite 360, ONINGS Mills, Md. 211

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Catherine Cunningham JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CLENTER MEDICAL WSON 105E Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Dec. 25, 1922 214-18-3473 Mary land 1 □ M 2**X** F **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Baltimore County Towson 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Completed by Funeral 21286 United States 409 Virginia Ave. Apt. 207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Bendix is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Margaret Schmitt ٥ James Slocum other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). **409 Virginia Ave. Apt. 207 Towson, Md. 21286** permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Mr. Charles E. Cunningham (Hus.) 20b. Place of Disposition (Name of Tuesday, Jan. 31, 2012 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cenetery Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Jeffrey I. Cair, Sr. CFSP Pare 101 Address Facilityes Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 Wr. M Lic.#M00677 23a. Port 1. Enter the disease of shock, or heart failure. List or complications Approximate DIFFICILE (NLITIS Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying as a consequence of Examin Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown the hed 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 L No 3 Probably 4 Unknown Completed 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 Other: ည 1 Zhopatient 2 -4 Nursing Home 5 Residence 6 Other (Specify, ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? hours after death.

uneral Director: A

sly filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral ! Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npletely

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To the F
complet State

> Registrar DHMH 17 Rev 06-2011

er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

5Le

Certifying Nurse Practition

on who completed cause of death (Item 23a) (Type, Print) A551

29b. Signature and title of certific

30/ Name and address

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death PATRICIA Physician/ Month AN CHROUSSIS Year 8:30 PM 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Locust Avenue Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/07/1968 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min. 1 🗌 M 2 💢 F Hours **Director** Maryland Yrs. 219-86-0771 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 52° ~ ~ ~ any injury or other traumatic event, the Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 707 York Road, Apt. 21204 5337 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Graphic Design Graphic Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Chroussis Bernadine Lilly Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Locust Avenue, Bel Air, MD 21014 <u>Janie Voelker / Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 01/26/2012 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCER -UNG SMALL CELL Physician/ disease or condition mon th Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 No 1 Yes Yes To Be 25. Was case referred to medical Sister's Residence filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manner of Death 1 Datural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 🔲 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

Date filed (Mont.)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY I. CONFINED, 6569 N. CL

Registrar's Signatu

027730

A. CHARLEST. SALTIMONE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#7perFH,G924,2/2/2012,WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Physician/ Theresa A. Conoscenti 2012 29 11:58 Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) Hours 215-16-0680 Director 1 □ M 2🏋 F 88 89 Yrs. Jan. 15 1923 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at with the Maryland Director 1 Yes 2X No MD Baltimore Timonium 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2525 Pot Spring Rd. 21093 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", Completed 3X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.

item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a Entertainment Party Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anthony Alasha Amelia Camarata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Stillway Ct., Cockeysville, MD 21030 If item 27 Joseph A. Conoscenti/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, /12 injury or 4 ☐ Donation 5 ☐ Other (Specify) Gärdens Timorium, MD 21093 Dulaney Valley Memorial Signature eral Savice Licen ee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. O W. Padoria Rd., Timonium, MD 21093 Michael J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician STABE ARDIAG disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events and burial-tra resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical ONDS CENTI, THERESA Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical filled in by the funeral director. 26. Place of Death (Check only one) Medical Certificate: To Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Collins		I- For State Registrar	State o	of Marylai			nt of He <i>te of De</i>	alth and Ment ath		Reg. No.	201	2 0226
Physiciar Medical Examin	1/	Decedent's Name (Fire	rst, Middle,Last)		1 6 11				2. Date of De Month January		Year	3. Time of Death 1956 hrs
~ · · ·		4a. Facility Name (if not		street and num	arles Coll	ins		y, Town, or Location o			. County of Dear	th
Funeral	٩	University Hosp 5. Social Security Number		17	7. Age (In yrs.	ast birthd		timore nder 1 Year I If Unde	r 24Hrs. 8. Date of B	lirth (MM/I	DD/YYYY) 9. B	irthplace (State or
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. "Litem 71 is marked other than "matural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married	2 Married	12. Was Dece Armed For 1 Yes		l.S. 1	If Yes, spe	ecify Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ame White, etc.	rican Indian, Black,
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21215-0036 Muld be filed within 72 hours after Mandl Hygiewie marked other than "natural", c event, the Medical Examiner	8			James Co	ollins						Herndon	
MD 21 d 2 should d 2 should ith and Me n 27 is ma	2	19a. Informant's Name/F Linda Mae Go				19b. I		•	ber or Rural Route Nu more, MD 212		ty or Town, Stat	te, Zip Code)
imore, MI Pages 1 and 2: nent of Health a rant: If item 27 or other traum	ŀ	20a. Method of Dispositi	ion					Name of cemetery,	Date		Location - City o	or Town, State
		4 Donation 5	Other Specify:		in State	Chesa		rematory	1/27/2012		Belts	ville, MD
Balt permit. Departi	I	21. Signature of Funeral Dorota Marshal		l Cl	Laulus	Ji.		ind Address of Facility land Crematio		BOX	1413Balti	more, MD 21203
Physician	1	23a. Part I. Enter the dis failure. List only on	ne cause on eac	h line.		n. Do not e	enter the mod	de of dying, such as ca	ardiac or respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final or condition resulting in		Multiple Inju ue to (or as a d		of):						Death
	<u>ا</u> ق	Sequentially list condition if any, leading to immediate	liate D	ue to (or as a	consequence	of):						
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Box 6876 e death certificate the attending phy ed for use as the b	clan	23b. Was decedent pregr past 12 months?	nant in the	1 Live bir	th int at time of d	2 [eath 5	Fetal dea		pregnancy		Month	Day Year
BO) he death the att	Physician/M	1 Yes 2 No 9		9 Unknov		an Itina i			et 23e Did	tobaccou	use contribute t	o the cause of death?
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Vital Recysician: The I	0 20	25. Was case referred to examiner? 1 ✓ Yes 2	-	ospital: 1 In	patient 2	ER/Outp	patient 3	26.Place of Death (Nursing Home 5	Reside	nce 6 Oth	er:
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Visior or Attence tifter death Director: in by the	Certification:	2 Accident 3 Suicide 6	Investigation Could not b	28e Place	of Injury - At h	lome, farn	n, street, fact	ory, office building, etc	c. 28f. Location	State)		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier 1 Cert	determined		Major Roa			the time, date and pla	Pulaski High	way and		r Road, Middle River, M
Fo the Forthin 2. Fo the Forthe	edical	one) 2 Med	licai Examiner:		f examination		estigation, in	my opinion, death occ	curred at the time, dat	e and pla	ice, and due to t	the cause(s)
	Σ	29b. Signature and title	of certifier	11	A			O.C.M.E.			Date signed <i>(M</i> u ary 25 , 201	lonth, Day, Year) 12
	-	30. Name and address of		ompleted cause	e of death (Iter					┷-		
		Melissa Brasse		sistant Med	lical Exami		00 W. Ba	Itimore Street, Ba	altimore, MD 212	223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 27°, 2012 17:05 January Frederick Cameron Crickenberger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 579-10-0941 1 X M 2 □ F 93 April 24, 1918 Virginia Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified 1 Yes 2 X No Maryland Cabin John Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a oi must be Funeral 3 Russell Road 20818 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working er than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 12 Aeronautical Engineer event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever မ Charles Walter Crickenberger Artie May Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18712 Flower Hill Way, Gaithersburg, MD Annette Bodnar/Daughter 20879 Department of Health Important; If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Feb. Parklawn Memorial Park 2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. willer a. Kinshees M01173 300 W. Montgomery Avenue, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Aspiration Pneumonia 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Adult Failure to Thrive cate has page 2 : autopsy Debility 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Hospice Hospital: ္ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 4 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Af Investigation Accident the 6 🗌

completely within 2 To the I

DHMH 17 Rev 06-2011

filled in by

Registrar

Medical

Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and fitle of certifier

Debrah Miller,

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R143201

29c. License number

6001 Muncaster Mill Road, Rockville, Maryland

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Regiftrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or P	rint in	Black Ir	ndelible In	k. Ensure A	All Copie	s Are	e Leg	ible.	
		For		State of N	/larylar			Health and N	_	_	-		00005
		State Registrar				Cer	tificate of I	Death		Reg. No	o.20	12	02265
Physicia	an/	1. Decedent's Nam		ŕ					2. Date of De Month	_	^y , 20	Year	3. Time of Death
Medic Examin			Lee Cha	give street and number,			4b City Town o	or Location of Death	Januar		. County		7:50 P ^M
Examin	ier	4802 Ox1					Rockv			40		tgome	ry
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Director	l	220-42-1 Usual Residence		1 □ M 2 🏋 F	69	Yrs.	Workins	110015 IVIIII.	Dec. 1		942		ngton, D.C.
and Show	 	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
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rs afte	ed b	3 Widowed		If Yes, Give Year or Dates.	LINO	1	∣ ☐ Yes 2 🗓 No	Specify:			Specify:	Wh	ite
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d be fi dental rked tic ev	은	Garland	Waters					Mae Hui			,		
should and N is ma auma		19a. Informant's Na	me/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or	r Town, St	tate, Zip C	iode)
und 2 s lealth rm 27 her tr				aney/Daught				rst Road	Bethe	sda,	Mar	yland	1 20817
ge 1 a nt of H : If ite or otl		20a. Method of Disp 1 X Burial 2		3 Removal from Stat	e	cemetery, cren	sition (Name of natory or other plac	00	Date	ĺ		City or To	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 21. Signature of Full	5 Other (Sp		Par		emorial Pa		ry 30,				Maryland
permi Depar Impo any ir once.		Willia) 11.	101173	3 Kć	bert A. Pi	imphrey Fund gomery Aven	eral Home	e, Ro	ckvil Mar	le, Ir	ac. 20850
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sician: The law r certificate has b lirector, page 2 s	Be	25. Was case referre examiner?	ed to medical	Hospital:			_ Oth	lace of Death (Checi				_	
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or Atter ter de irecto n by tl	Certificate:	3 Suicide 4 Homicide	6 Could no determin	28e. Place of Ir	jury - At ho tc. <i>(Specify</i>		eet, factory, office		28f. Location (S			r or Rural i	Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate has been signed by the attending physici To the Luneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of Nurse Practitioner: To t	examination	n and/or invest	igation, in my opinio	on, death occurred at	the time, date a	and place	and due	to the cau	se(s) and manner stated.
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. I W.		30. Name and addre	ss of person wi	ho completed cause of	death (Item	23a) (Type, P	rint) 52	y Han	Rrsb	Ury	y F	·~	
Char		31. Date filed (Month	To Day Ward	RECWER 32. Regist	7	UD	5 911	Vex 8/	Delsi	m	D	500	704
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20 bt Re of War 6924 /2/93 ar 20 e 2 Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2 Physician/ CHAVIS 0909A:M JAMES January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** and Samaritan Hospita 30Himore N/A 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Months Days Hours 08/29/1941 Virginia 223-54-8898 70 **Director** Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 11710 Tuscany Dr. 20708 U.S.A death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. than "natural", or iter the Medical Examiner Armed Forces?

1 2 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) vears Flight Mechanic Air Force nt of Health and Mental Hygi : If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Percell Chavers Clyde Marie Parham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capri Chavis(wife) 11710 Tuscany Dr., Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Str 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Department o Important: If any injury or on-site Cremation 02/01/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, 21. Signature of Funeral Service Licenses Josephadas of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COP -M. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate | 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director; 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 2 1, M.D. ASHIDHARAN State

Registrar

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Z o to	O to the control of t	the MO
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one) a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one) and certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one) and certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one only one only one of the cause(s) and manner as state on the cause(s) and manner as state only one of the cause(s) and manner as state on the cause(s) and manner	ause(s) and manner stated.
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
- Hanlay regarders to the the state of the	State 31. Date filed (Morth, Day, Year) Registrar State A S Greene St Balkmore MD 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ $P^{\,\mathsf{M}}$ 2012 Elizabeth Virginia Dey Januarv 6:08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Agnes Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 216-16-1379 1 □ M 2 🖁 F Director 89 Apr. 3, 1922 Maryland ms 23a or 28a-f show must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6000 Chesworth Road 21228 United States or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: "natural", White 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Social Security Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Clerical Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, th and Mental I ၉ Melvin Alexander Mary Elizabeth McGinnity 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health Mary Louise Huller/Sister 402 Crosby Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. Loudon Pk. Cemetery 02/03/12 Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Alyson K Taylor 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final EMBOLISM Physician/ disease or condition resulting in death) Medical Examiner THROMBOCY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ျှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural hin 24 hours after death. the Funeral Director: After (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifie 29b. Signatur 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE, BALTIMORE, MB MO RICHARDSON

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 012 Physician/ Jan. 24. 04:00а м Bruce L. Dahlweiner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospice of the Chesapeake Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 6 Sex 7. Age (In vrs. last birthdav. 9. Birthplace (State or Foreign **Funeral** Days Hours July 25, 1949 1 ₺ M 2 🗆 F Months Vrs Marvland 62 **Director** 216-58-0972 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10a State 10c, City, Town or Location 10d. Inside City Limits Director 1 Sy Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21229 4301 Alan Drive Apt D. death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2XXMarried Saltimore, Maryland 21215-0036 72 hours after nan "natural", o Medical Exan If Yes, Give Year or Dates 1 Yes 21 No Specify. White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Law Enforcement Police Dispatcher event, Be Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Shaffer Doris H. Elmer Charles Dahlweiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3656 Greenvale Road Baltimore, MD 21229 Elaine Shaffer / Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory Jan.29, 201**2**GlenBurnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Juneral Service Licens 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) na Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed hours after charth.

Ineral Director. After this certificate has been signed by the attending physician and dilled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 | Yes 2 L 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No ☐ Yes 2 No FOSO 25. Was case referred to medica Be 26. Place of Death (Check only one) 100 examiner?
1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 No ☐ Àccident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760

Stat Registra		31. Date filed (Month Law San 2012 34. Registrar's Signature	· · · · · · · · · · · · · · · · · · ·	
Chai		31. Date filed (Month Day, Year) 1040 38. Registrar's Signature		10
+1		(Kussell Delmard 305	Hospital Dina	(N/nBrom/4/2106)
		38. Name and address of person who completed cause of death (Item 23a) (Type, Print)	`	/ 1
			03/15/	January 25,2012
To the within To the comp		29b. Signature and title of gertifier	29c, License number	29d. Date signed (Month, Day, Year)
he Ho in 24 h he Ful pletec	Med	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death		

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

City or Town, State

4 Homicide

29a, Certifier

ical

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 02270

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Physicia		Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of Dear		3. Time of Death
cal Exami	ner		y Mae Dar					January 2	7, 2012	1346 hrs
		 Fecility Name (if not institution, University Hospital 	give street and number)		ľ	tb. City, Town, o Baltimore	r Location of Death	1	4c. County of De	ath
			5. Sex 7. Ag	e (In yrs. las	st hirthday)	If Under 1 Ye	ar If Under 24Hrs	8 Date of Bir	th (MM/DD/YYYY) 9.	Birthplace (State or
Funeral Director		217-22-5060	1 M 2 F		4 Yrs	Months Da			1007 For	eign Country) PA
k 6	H	Usual Residence of Decedent 10a. State 10b. County		10c. City. T	own or Locat	on				10d. Inside City Limits
T 80 4		And the second s	imore		White	MArsh				1 Yes 2 X No
Maryland 28a-f show d at once.	용	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	ountry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 'Hem 27 is marked other than "natural", or items 23a or 28a-f sho	al Director	11611 Jerome			140.141	211			USA	erican Indian, Black,
eath wi	Funeral	11. Marital Status 1 Never Married 2 Mar	ried 12. Was Decedent Armed Forces? 1 Yes 2				ispanic Origin? (S in, Mexican, Puerto		White, etc	
fter d	by F.	3 X Widowed 4 Divor	rced If Yes, Give Yeer or Dates:	kr No	1	Yes 2 N	o specify:		Specify:	White
ours a	윤	15. Decedent's Education (Specif	ly only highest grade con	npleted)			ation (Give kind of e. DO NOT use ret		16b. Kind of Busines	s/Industry
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	Cle	_	0. 20 1101 400 101		Clark P	rinting Co.
MD 21215-0036 d 2 should be filed within 7 dth and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	틍	17. Father's Name (First, Middle, L	_ast)						Maiden Surname)	
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AD 21 2 should h and Mer 27 is man	은	19a. Informant's Name/Relationshi								ate, Zip Code 30741
e, MC I and 2 si Health ar item 27		Garland 20a. Method of Disposition	Staples/s			South		n Rodg	e Drive 1 20c. Location - City	Rossville G
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other trans		1 X Buriar 2 Cremation	3 Removal from St	ate Ho	ematory or of	ill Ce	metery		Baltim	ore MD
ltim iit. Pa urtmen ortant ry or o		4 Donation 5 Other-Spe 21. Signature of Funeral Service L							Ave. Ba	
Balt permit Depart Impor injury		(MUXIU	a) Bare		1	Conne.	lly Fune	eral Ho	ome of Es	sex 21221
hysician		23a. Part I. Enter the disease, or of failure. List only one cause of		the death.	Do not enter t	ne mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
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760, ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregn	-	tal death 3	Ectopic pregna	ancv	23d. Date of deliv Month	ery Day Year
Box 6876 e death certificate the attending phy ed for use as the le	Physician/	past 12 months?	4 Pregnant at	time of dea	th =	her (Specify)				
Bo e deat the att	hys	1 Yes 2 No 9 Unkn	3 OTIKIOWIT					Log. Bid.		to the course of death?
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of Vital Records, Replysicae: The law require After this certificate has been si meral director, page 2 should be	Completed							autor		o completion of cause of
	ပ္ပ							1 ✓ Yes		Yes 2 No
Vital ysiciao: his certif director	Be	25. Was case referred to medical examiner?	Hospital:	nt 2 0	ER/Outpatient		Other Nursi		Residence 6 Ot	her:
of Vi Physic rer this eral dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of Iniu	ırv I	28b. Time of I		ury at Work?		how injury occurred	
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Division ital or Atteodis us after death.	fica		igation 28e. Place of Ir	njury - At hor	ne, farm, stre	et, factory, office	building, etc.	28f. Location (or Town, S		Rural Route Number, City
Divis Hospital or A 24 hours after Fuocral Dire tely filled in t	Certification	4 Homicide determ	nined (Specify) Ma	ijor Road	/ Highway			Philadelphia	Road at Maudes W	ay, White Marsh, MD
the Hin 24 the Fu	Medical		ysician: To the best of mainer: On the basis of exa							
F witi	Me	29b. Signature and title of certifier	and manner stated.	1)	29c Licer	ise number		29d. Date signed (Month, Day, Year)
		Callle	NO		2	0.0	.M.E.		January 28, 20	012
b		30. Name and address of person v	•			Paltimore St-	agt Paltimara	MD 21222		
	tate		ssistant Medical E	Bila Ciana A.		Jaminole Str	cei, Daililliole	, 1411 2 1223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EUNICE DEVAULT JANVARY 2.30 PM MARIE 25 28/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** COUNT HO WARD COLUMBIA LEWERAL to WARD Login **Funeral** Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Months Days Hours Nov 20, Day 923 Country 88 **Director** 316-12-2965 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XX Yes 2 □ No MD Howard Columbia 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? þe must be Funeral 6500 Freetown Rd 21044 USA items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. , 0 þ 1 Never Married 2 Married Yes 2 XX No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify. 3 XXWidowed 4 □ Divorced "natural" Completed Year or Dates. White ed other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) fitem 27 is marked of 18. Mother's Name (First, Middle, Maiden Sumame) မ Lester Bruff Neva Chaplin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark DeVault 6117 Covington Rd., Columbia, MD 21044 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ± 5 ☐ Burlal 2 XX Cremation 3 XX Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Bayview Crematory Jan 27, 2012 Baltimore, MD 21. Sign, un of Funeral Service 22. Name and Address of Facility
Fink Funeral Home, P.A. Gregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 mplications that caused the death. Do not enter the mode of dying, such as cardiąc or respiratory arrest, 23a. Part 1. Enter the Approximate shock, or heart fall Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed buriaf-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 🗆 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 Yes Yes or Attending Physician: in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 🖪 မှ 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 1 ☐ Yes 2 ☐ No Accident 🔲 Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completed filled ir Hospita 6 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie ٥ 29d. Date signed (Month, Day, Year) January 30641

DHMH 17 Rev 7/2009

State

Registrar

Kames

31. Date filed (Month, Day, Year)

201-109

32. Registrar's Signature

BACK RIVERNECK ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapalhi

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f s edical Examiner must be notified

10

permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce.

Physician/ Medical **Examiner**

physician and s the burial-transit

attending p

signed by the a d be detached f

certificate has been si rector, page 2 should

director,

within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					Interval Between Onset and Death
disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	cungo	ANCOR		MONTH
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	juence of):				_
Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi			23d. Date of delive Month	ory Day Year
Part II. Other significant conditions COPONARY	-			1 🗆 Yes		ably 4 Unknown
				24a. Was an autopsy performed?	prior to cor death?	sy findings available inpletion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)		
1 Yes 2 Wo	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 Q Other (Specify)	1-05P162
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work?	28d. Describe how inj		
3 Suicide 6 Could not determined		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, Sta		Route Number,
(Check 2 Medical Exar	ysician: To the best of my know niner: On the basis of examination rse Practioner: To the best of m	on and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the cau	se(s) and manner stated
29b. Signature and title of certifier	1 111	7 2	9c. License number	29d. I	Date signed (Month, D	Day, Year)
1 1/1/1/1/1/	1 1 1 1		1 16H - 2 -			1 1 1117

State Registrar completed ause of death (Item 23a) (Type, Print)

JAN 3 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012

			State Registrar	Cer	tificate of Death		Reg. No.	
	Dharisis	. ,	1. Decedent's Name (First, Middle, Last)			2. Date of D		3. Time of Death
	Physicia Medic		Judson W. Drennan			Januar	ry $2^{D_{2}^{3}}$, 201^{9}	11:20 P M
- Maria	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of De	
- Services			Shady Grove Adventist Hosp 5. Social Security Number 6. Sex 7. Agr		Rockville	4 Hrs. 8, Date of B		irthplace (State or Foreign
	Funeral Director		5. Social security number 577-92-6359 Usual Residence of Decedent	e (In yrs. last birthday) 44 Yrs.	Months Days Hours	Min. (Month, I June 16	Day, Year) 1967 Inc	diana
	and show	ا ا	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	faryla 8a-f s tified	Director	Maryland Montgomery	G	Saithersburg			1 ☐ Yes 2🛣 No
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 8149 Morning View Drive	-	10f. Zip Code 20877		10g. Citizen of What C United Sta	*
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent 8 Armed Forces? 1 □ Yes 2 ☒ If Yes, Give Year or Dates.	No I	Was Decedent of Hispanic Origi if Yes, specify Cuban, Mexican, 1 Yes 2 X No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Black, Wh	nerican Indian, ite, etc. nite
21215-0036	ithin 72 hou ene. • than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give i	dent's Usual Occupation kind of work done during most of O NOT use retired) Carrier	of working	16b. Kind of Busines United S Postal Se	tates
Maryland 2	be filed wi ental Hygia rked other ic event, t	ம	17. Father's Name (First, Middle, Last) David Nix	<u> </u>		's Name (First, Middl na Jane J	le, Maiden Surname)	
ary	nould ind M s mai		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number			
Σ	d2st alth a π27ie		James B. Drennan/Brother	209 S	. Butting Aven	ue, #101,	Virginia B	each, VA23452
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or otho		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Montgomer Crematoria	in Inc.	anuary 30, 2012	Bethesda,	Maryland
Balt	permit. Departr Imports any injt		21. Signature of Funeral Service Licensee	M01498 B	2. Name and Address of Facility Bethesda-Chevy ethesda, Maryl	Robert A. Chase In and 20814	Pumphrey F c. 7557 Wis	uneral Home consin Avenue
		П	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente				Approximate Interval Between
-41	Physician/				norrhage, Non-t	ramatic		Onset and Death
	Medical		a.	a consequence of):	0 ,			
	Examiner	L	Sequentially list conditions, b.					
	7 E	ine	cause. Enter Underlying	a consequence of				
	ecuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as	a consequence of):				
_	oe exe	la E	resulting in death) East	a consequence on.				
8760	physi the l	Medical	d					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of o	delivery Day Year
, P.O.	es that th signed by be detac		Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause given in Part I.		d tobacco use contribute	to the cause of death?
rd	requi	etec				24a. Wa		autopsy findings available
Reco	The law cate has by	Completed by				au pe 1 🗆 Ye	topsy prior t rformed? death	o completion of cause of
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		26. Place of Death			
n of V	ding Phys th. After this funeral d	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation			28d. Describe	esidence 6 Other (Sp.	ecify)
Division of Vital Records,	To the Hospital or Attending Physician: The taw within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could not be	ury - At home, farm, str c. (Specify)	eet, factory, office		(Street and Number or F own, State)	Rural Route Number,
_	e Hospital 24 hours e Funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of the desired Examiner: On the basis of the desired Examiner: On the basis of the desired Examiner: On the desired Examiner:	xamination and/or inves	stigation, in my opinion, death occ	curred at the time, date	e and place, and due to th	e cause(s) and manner stated.
	To the within 2 To the comple	-	29b. Signature and title of certifier	, , ,	29c. License number		29d. Date signed (Mor	nth, Day, Year)
	A 6 .		I Chips char m.	D .	рооб5505		January 23	3, 2012
	John		30. Name and address of person who completed cause of c Quifang Cheng, MD 9901 M	leath (Item 23a) (Type, F edical Cen	Print) ter Drive, Roc	kville, Ma	aryland 208	50
Ī	Sta Registr		31. Date AMS in Dall 2 Cleans 32. Registr	's Sign				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 7,8,18 per fh 19925 3-2-12 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20, 2012 6:50 P M Frank Boyd Dennisson Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda National Institutes of Health 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1938 9. Birthplace (State or Foreign 6. Sex Funeral 1 X M 2 □ I Months Days Hours Min. April 30, Year New Mexico 525-78-5859 73 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f shomust be notified at 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏝 No New Mexico Santa Fe Stanley 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 87056 United States 3810 Highway 41 2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1956—1960 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Be Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dennisson Construction Water Well Driller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Vanscoyk M. Van Sooyk permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic s Harold Pearl Dennisson 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3775 Highway 41, Stanley, New Mexico, 87056 Bill Dennisson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Stanley Cemetery Date 20c. Location - City or Town, State ⊠ Burial 2 □ Cremation 3 □ Removal from State January 27, 2012 4 Donation 5 Other (Specify) Stanley, New Mexico Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 22. Name and Address of Facility Robert 21. Signature of Funeral Service License Α. Bethesda-Chevy Bethesda, Mary M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) less than 24hr Hypoxia Medical Due to (or as a consequence of): Examiner Metastatic Mesothelioma less than 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the huria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ed by the g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of countries of the basis of the ba 29b. Signature and title of certifier 29c. License number (SHOLAMON 0101249001 Rusah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Center Drive, Bethesda, Maryland 20892 Shannon Rosati, 32. Registre 's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State OT IVI			Ith and Mental Hy	201	2 02275
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Dea	2. Date of De	Reg. No.	
	Physicia Medic	al	Anna C. Davis			Januar	ry ^D 26.201	2 10:50P M
	Examin	er	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Care	2	4b. City, Town, or Loca Towson	ation of Death	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birthday) 32 Yrs.		Inder 24 Hrs. 8. Date of Bird ours Min. Jania	h 9. Bi	rthplace (State or Foreign
	ld now at	_	Usual Residence of Decedent 10a. State 10b, County	10c. City, Town or Lo	ecation	-		104 1
	larylar Sa-fsk ified	Director	Md. Baltimore		ws Point			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M or 28 e not	Ö	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	
	h with	Funeral	12 Turtle Court		2121		U.S.A	•
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent 1 Armed Forces? If Yes, Give Year or Dates.	KNO	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 🌁 No Spe	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) ecify:	14. Race - Ame Black, Whit Specify: Wh	te, etc.
2-0	hour fnatur	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation	most of working	16b. Kind of Business	Industry
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<u>√</u>	and 2 : Health em 27 ther tr		Richard Henninger, Sr.					
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	4-	crematory or other place)			,Maryland
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			1 - State Amend Item 20 Registrar	State of N per ver	larylan	d/, Depa 23,017 Cer	rtment of 1 72012 tificate of	Health an Inb Death	nd Ment	al Hygie	ene 1. No. 2 N	12	02276
	Physicia	<i></i>	1. Decedent's Name (First, Middle, Las	st)					2. D	ate of Death	Euron No.		3. Time of Death
	Medic		Brutus A. Edwa						O ^N	onth 2	4 ^{Day} 20	1 ^Y 2 ^{ar}	12:30pм
	Examir	ner	4a. Facility Name (if not institution, give Gilchrist Hosp	,				or Location of D	Death		4c. County		
	Funeral		5. Social Security Number 6. S		ge (În yrs. la	st birthday)	If Under 1 Yea	imore	Hrs. 8 Da	ate of Birth	N/Z		lace (State or Foreign
	Director		217-38-5108	X M 2 🗆 F		O Yrs.	Months Day			Sonth Day, Ke	7941		arolina
	ld t	_	Usual Residence of Decedent 10a. State 10b. County		100 City	. Town or Loc	-ti						
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	he Ma or 28	ğ	10e. Street and Number				10f. Zip Code	altimo	re	100	a. Citizen of W	/bat Coun	21
	with t	Funeral	301 McMechen S	t. Apt 1	207			1217		100	U.S.		шу:
	death items ier mi	Fun	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		as Decedent of	Hispanic Origina ban, Mexican, Po	? (Specify Ye	s or No-		- America	an Indian,
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21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates.								Bla	
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pu	× T = =	To Be	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First,		den Surname)		
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Maryland	of Health and Mental Health and Mental Health and Mental Health 27 is marked or other traumatic ever		19a. Informant's Name/Relationship (T) Phyllis Albrigh		~ \	1							ode) 21215
ē,	f Hea item other		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of	Height:	S AVE		c. Location -		
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fur eral Service Licens	A	2			,					
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П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ne cause on each lin	ie.		-	-					Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. SQIAN	1005	cell c	Gran	na of b	read 1	and he	ck		Onset and Death
مهمدوب	Examiner		·	Due to (or as	a conseque	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of,.			_				
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09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical		d						_		\perp	
687	eath certifica attending pl	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	CV							
Вох	ath c atten I for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a	2 Fetal	death 3 🗌	Ectopic pregna Other (specify)	ncy			23d. Date Mon	of deliver th	ry Day Year
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ds,	equire:	ted							_	1 🗌 Yes	2 □ No :	3 🗌 Prob	ably 4 🗷 Unknown
00	law re has be je 2 sh	nple							24	4a. Was an autopsy	nq	ior to con	sy findings available npletion of cause of
æ	Physician: The lav r this certificate haveral director, page 2	ပ်							1	performed Yes 2	d? de ₽No 1	eath?	2 🗆 No
ital	sician certifi rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		_	I Ot	Place of Death (C			``		TT .
of V	g Physer this eral di	e: 10	27. Manner of Death	28a, Date of inju	irv 2	R/Outpatient 28b. Time of	3 ∐ DOA 28c. Inju	4 L Nursin			e 6 N Other		Hospice
uo :	anding ath. r: Afte ne fun	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y, Year)	injury	wo		- 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	njary occurred	-	
Division of Vital Records,	r Atter de trecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At hom	ne, farm, stree	t, factory, office			cation (Stree		or Rural F	Route Number,
ה ה	oital o												
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/ ;	Vithin To the comp		only one 3 Certifying Nurse 29b. Signature and title of certifier	e Practioner to the	nest of my k	Khumieogei, de	29c. Licen		s place, a 10 c		Date signed		
			Afterent	ny			700	5830	3		nvari		1 2012
			30. Name and address of person who co			(Type, Pri	nt)	1					
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ı	Physicia	n/	1. Decedent's Name	e (First, Middle	, Last)		SE	IST					2. Date of De Month	_ D	ay 2	Year	3. Time of Death
-	Medic Examin		4a. Facility Name (if		, give stre	1	er)		4b. City, 7	Town, or			01		c. County		
	Funeral		14363 5. Social Security N	Umber	6. Sex	4 7	'. Age (In yrs.	last birthday)	If Under		If Under		8. Date of Bi	rth	NON	g. Birthpl	Mercy lace (State or Foreign
	Director		416-68-6 Usual Residence of	792 Decedent	1 📙	M 2 🗹 F	6C	Yrs.	Months	Days	Hours	Min.	8mo19 D	795	7	Actual	Bana
	Maryland 28a-f show otified at	ctor	10a. State	10b. County	201	1.01	10c. C	ity, Town or Lo	0	0 - 1		_				10	0d. Inside City Limits
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Nun		501	neey		5114	10f. Zip	Code	NG-			10g. C	itizen of V	What Count	
	items 23a	nera	14363	Bel	tre	Dri	re	0 401	Non December	20	1-	Q	if . Veg ev Ne		U-3		4
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Marri 3 Widowed		ried	2. Was Deced Armed Ford 1 Yes 3 If Yes, Give Year or Date	es? 2 No	'	f Yes, speci	fy Cuban	, Mexicar	i, Puerto F	cify Yes or No Rican, etc.)	-		e - America B A	
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Man	12 should lith and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Na		nip (Type,	Prin B	2W /	19b. Mailir	-		nd Numbe		Route Numb	1 '	1	State, Zip Co	ode)
	ge 1 and t of Heal If item or other		20a. Method of Disp	osition			20b.	Place of Dispo				3,0	ate	<u> </u>		City or Tov	vn, State
Baltimore,	t. Pag tment rtant: njury		4 Donation	5 Other (S	Specify)		G.	ate o	+++	(D) (C)	4	2-4	20/2	51	Iver	1 1	(IM, ENI
Ba	Depar Depar Impor any ir		21. Signature of Fur	Lie L	C .	owe	Uh.)0	. Name and	G-U	H'H	ord ord	Road	1-5	GS21 Novo	- 1	1D 20794
ı			23a. Part 1. Enter to shock, or hear Immediate Cause (t failure. List o				th. Do not ente	er the mode	of dying	, such as	cardiac o	respirato (B	rest,			Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)		a .	Jue la for	a consec	quence of):	pri	D	-11	ye	nu	_	7	-	
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Вох	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medica	in the past 12 r 1 Yes 2 D				ant at time of	tal death 3 L death 5 L	Ectopic pr Other (spe						Moi		Day Year
P.O.	that the ned by	y Ph	Part II. Other signif	cant condition		_ '	·	sulting in the u	nderlying ca	ause give	en in Part I	l.	23e. Did	tobacco	use contr	ibute to the	e cause of death?
rds,	equires een sig nould b	eted	0	2 01	0	VI	ac	gu	>				1 🗆	Yes 2			ably 4 🗌 Unknown
Records,	he law r te has b age 2 sh	omple					<u> </u>						24a. Was auto perf 1 Yes	nsv	l r	orior to con death?	sy findings available inpletion of cause of
tal F	hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referre	ed to medical		- 7-1				_	ce of Deat	th (Check		2 161	lo <u>l</u> 1	1 Yes 2	2 ∟ No
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o uo	ending eath. or: After he funel	ficate	1 Natural 2 Accident	5 Pendin	gation		, Day, Year)	injury	M 28	c. Injury work?		- 1	8d. Describe	how inju	ry occurre	ed	
Division	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical Certificate:	3 Suicide 4 Homicide	6 L Could determ	ined	building	g, etc. (Specif						City or To	wn, State	e)		Route Number,
)	he Hosp in 24 hou he Fune ipleted fi	Medic	(Check 2	Medical E	xaminer	 On the basis 	of examination	vledge, death o on and/or invest ny knowledge, o	igation, in m	y opinion	, death oc	curred at	the time, date	and plac	e, and due	e to the caus	se(s) and manner stated
	with		29b. Signature and t	ain	۰	Au	elg		D	License I	number 45	29	6	29d. Da	ate signed	(Month, D	ay, Year)
	A		30. Name and addre	ess of person v	who com	pleted cause	of death (Iter	m 23a) (Type, P		1 (2810	o Co	nnetic	ot A	ve	Kensi	ing ton, MO
•	Stat	е	31. Date filed (Month		2 /	32. Reg	gistrar's ligna		9				/ -				20895

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		-	For State Registrar		Stat	e of IVI	aryland		artmen <i>tificate</i>			Mental Hy	/giene Reg. No	201	2 (12278
			Decedent's Name	e (First, Middle, I	_ast)							2. Date of De	eath		3. T	Γime of Death
	ysicia Medic		Sandra	Jean	E1bur							Janua				:15 P M
E	kamin	er	4a. Facility Name (if			d number)					Location of Deat		40	County of Dea		1
Fu	neral		205 Hill 5. Social Security N		. Sex	7. Ag	e (In yrs. la:	st birthday)	If Under	1 Year	lyn Par	8. Date of Bi	rth	9. B	rthplace (State or Foreign
	ector		216-44-1		1 🗆 M 2 💢	F	65	Yrs.	Months	Days	Hours Min.	03/15/	1946	Ma	untry) iryla	nd
nd j	at	ō	Usual Residence of 10a. State	10b. County			10c. City,	Town or Loc	cation						10d. In:	side City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hydiene.	otified	Funeral Director	MD	Anne	Arund	le1				Bro	ooklyn F	ark			1	Yes 2 No
th the	t be n	al D	10e. Street and Nur						10f. Zip	Code	01005		10g. C	itizen of What C		٨
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fer de	mine	by F	1 Never Marr		d Arme	ed Forces? Yes 24	No		Yes, speci			pecify Yes or No to Rican, etc.)		Black, Wh	te, etc.	
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e filed	even	To Be	17. Father's Name (•							me <i>(First, Middle</i> ria Jord		Surname)		
ould b	matic		19a. Informant's Na					19b Mailin	na Address	(Street a		ural Route Numb		r Town, State, Z	ip Code)	
d2sh althar	er trau		Mr. Char	•		ı / hu	sband		•	,	st Aven			lyn Parl		21225
e lan of He	r othe		20a. Method of Disp	position XXCremation 3	Removal	from State		ace of Dispo emetery, cren				Date	1	ocation - City c		
t. Pag	jury		4 Donation	5 Other (Sp	ecify)		At.	lantic			-	/2012				laryland
permi Depal	any in	Ŋ	21. Signature of Fu	neral Service Lic	ensee		MUI:					ngleton Ave SW				ation MD 21061
		\neg	23a. Part 1. Enter t	the disease, or c										<u> </u>	Appr	roximate val Between
Physi			Immediate Cause disease or condition	Einal	y one cuese	A	vomi	nd	200	Pour	CAR CAR					et and Death
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certifi	usea	an/N	IF FEMALE: 23b. Was decedent			s, outcome Live Birth			Ectopic p	reananc)	1		- 1	23d. Date of d	elivery	
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hat the	detact	y Ph	Part II Other signif	ficant condition	s contributing	to death b	ut not resu	ılting in the u	nderlying o	cause give	en in Part I.	23e. Did	tobacco	use contribute	o the cau	use of death?
uires t	ad blu	Completed by	Typl 1	I Devil	sete.	Nelle	tus					1 🗆	Yes 2	No 3□	Probably	4 🗌 Unknown
w requires	2 shot	plet	(//									24a. Was	s an			ndings available ion of cause of
The la	page	Com											formed?	death?	es 2 🗆	No
sician:	rector,	Be (25. Was case referr examiner? 1 Yes 2	red to medical No	Hospital:				- 🗆 -	Othe	r:	, ,				
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ending eath.	he fun	ficat	1 Natural 2 Accident	5 ☐ Pending Investiga	tion	(Month, Da	y, rear)	injury	М	work?	Yes 2 No					
or Att	in by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	od 28e. F	Place of Injudual		me, farm, stre	eet, factory	, office		28f. Location City or To		nd Number or F e)	ural Route	e Number,
To the Hospital or Attending Physician: The law within 24 hours after death.	filled		29a. Certifier	Certifying F	hysician: To	the best of	my knowle	edge, death o	occured at	the time,	date and place,	and due to the c	ause(s) a	and manner as s	tated.	
he Ho in 24 h	pleted	Medical	(Check 2	Medical Ex	aminer: On th	ne basis of e	xamination	and/or invest	tigation, in r	my opinio	n, death occurred		and plac	e, and due to the	e cause(s)	and manner stated.
To t	com	5-1	29b. Signature and	title of certifier	Oc	100			29c.	. License	number		29d. D.	ate signed (Mor	th, Day, Y	'ear)
			Crik	Z. Prus	no completed	ווען	eath (Item	239) (Time	Print)	¥ <u> </u>	625		4	SONIS	1	
			Erik L. A	Russell Y	N.b.,7	711 (rinte	ertiol	IRA	Sal	te A. GA	en Schmit	M	wan	d =	71401
	Stat		31. Date filed (Mont			32. Registra	ar's Signate	ure	/	1	1		1	1	1	
Re	egistra	ar	JAN	3 1 2012	Chara	we.	B. 4	Jacker								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02279 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	f Death		Reg. No.	
Physic		Decedent's Name (First, Middle,Last)			2. Date of	Death	3. Time of Death
cal Exam	nine	Pamela 1	L. Evans		Month Jan⊍ar	y 28, 2012	1916 hrs
		4a. Facility Name (if not institution, give street	et and number)	4b. City, Town, or Loca	tion of Death	4c. County of Dea	ath
		1503 N. Caroline Street		Baltimore		n/	, a
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If	Under 24Hrs. 8. Date o	f Birth (MM/DD/YYYY) 9. B	Birthplace (State or
Director		212-76-0112 1 M	2XF 51 Yrs		lours Min.	Fore	eign
	1	Usual Residence of Decedent	2[X]F 51 Yrs	<u>``</u>	Apr	il 24,1960	country) MD
any .	ı	10a. State 10b. County	10c. City, Town or Local	tion			10d. Inside City Limits
* .	١.	MD		_			1 X Yes 2 No
Aaryland 28a-f show	ļ	10e. Street and Number	Ba	ltimore		1	
r 28	Director			10f. Zip Code		10g. Citizen of What Co	untry?
ith the Maryland 23a nr 28a-f sho notified at once.	0	1503 N. Caroline	e St.	212	13	USA	
h wii	Funeral				Origin? (Specify Yes or kican, Puerto Rican, etc.)		erican Indian, Black,
deat in it.	٦	1	Yes 2 X No	es, specify Cubari, INEX	kicali, Fuelto Ricali, etc.)	White, etc.	
after lie.	>	3 Widowed 4 Divorced If Yes, or Date	tes:	Yes 2 X No spe	ecify:	Specify: B	lack
5-0036 led within 72 hours Hygiene. Inther than "natur the Medical Exami	듗	15. Decedent's Education (Specify only high		nt's Usual Occupation (Coost of working life. DO I		16b. Kind of Business	s/Industry
6 72 72 8 18 18 18 18 18 18 18 18 18 18 18 18 1	Completed	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	lost of working life. DO	NOT use retired)		
Ar the British	ᄩ	35	years Day C	are Provi	der	Self Em	ploved
5-0 led v	ပိ	17. Father's Name (First, Middle, Last)		18.Mc	other's Name (First, Midd		• •
21215-0036 uld be filed within 7 Mental Hygiene. marked nither than c event, the Medica	Be	John Gilbert Ev	ans		Audrey	L. Hudgi	ns
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. (rem 71 in marked inther than "natural", in items 23a nr 23a-f she fraumatic event, the Medical Examiner must be notified at once	유	19a. Informant's Name/Relationship (Type, P		g Address (Street and	Number or Rural Route	Number, City or Town, Sta	te, Zip Code)
MD d 2 sho lith and n 27 is		Sonya Johnson/Sis	ster 3309	Glen Ave	. Baltimo	re Md. 212	15
Healt Item		20a. Method of Disposition	20b. Place of Dispos	ition (Name of cemeter)		20c. Location - City of	
Baltimore, MD 2121: oemit. Pages I and 2 should be fil epearment of Health and Mental important: If itee 27 is marked alury or rather fraumatic event,		1 X Burial 2 Cremation 3 Re	• • • • • • • • • • • • • • • • • • •				
ting the Line of t		4 Donation 5 Other Specify:		Cem.	Feb.6,2	0 1 2 Balto.	, Md
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked ather thinjury are other traumatic event, the Mediup are after traumatic event, the Medius and the present of the Medius and the present of the Medius and the Medius are not the Medius and the Medius and the Medius are not the Medius and the Medius and the Medius are not the Medius and the Medius and Medius	1 8	runeral sectica Licansea		Name and Address of Fa ${\tt CALVIN}_{\tt L412} {\tt E.} \dot{\tt P}$	SCRUGGS	FUNERAL HO BALTIMOR	ME
	-	23a. Parti. Enler the disease, or complication	as that sourced the death. Do not enter the	1412 E. P	RESTON ST	. BALTIMOR	
hysician/ Medical		failure. List only one cause on each line	i.			arrest, snock, or neart	Approximate Interval Between Onset and
Examiner		100	mplications of chr	onic alcoho	ol use		Death
		Due to	(or as a consequence of):				
	F	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):				
	틭	rause: Enter Underlying Cause	(5. 25 4 55/105445/105 5/).				5-1
_ =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to	(or as a consequence of):	<u> </u>			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the artending physician and page 2 should be detached for use as the burial - transit		d.					
e exection in all -	/Medical	■ UNPENDED	NDED 23a,27,per me,	g924 2-8-12	2 sm	· · ·	
760, ficate be g physici	Σ	IF FEMALE: 23c.	If yes, outcome of pregnancy		-	23d. Date of delive	- I
30x 687 death certifi e attending	an/	23b. Was decedent pregnant in the past 12 months?		tal death 3 Ec	topic pregnancy	Month	Day Year
Box 68 e death certi the attending ed for use as	잃	1 Yes 2 No 9 V Unknown		her (Specify)		F	Ť
the de f	Physician	9_	Unknown				
P.O. s that the gned by detacl	by F	Part II. Other significant conditions contrib	outing to death but not resulting in the u	ınderlying cause given i		d tobacco use contribute to	
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ital ician: s certif rector,	Be	examiner? Hospital	·		eath (Check only one)		
FV; Physical this	유	1 ✓ Yes 2 No	impatient 2 ER/Outpatient			Residence 6 Othe	er: Scene
ding Afte	ü	1 X Natural	a. Date of Injury (Month, Day, Year) 28b. Time of In			be how injury occurred	
Sior ttend death. ctor: y the	ati	2 Accident Investigation		1Yes 2	No		
Division tal or Attendi rs after death.	ij	Suicide Could not be	Be. Place of Injury - At home, farm, stree	et, factory, office building		n (Street and Number or R n, State)	ural Route Number, City
Divis pital or At ours after d neral Direc	Certification:	- I Hornicide	Specify)			, state)	
Frun 24 h Frun etely		29a. Certifier (Check only 1 Certifying Physician: To	the best of my knowledge, death occur	red at the time, date and	d place, and due to the ca	ause(s) and manner as sta	ted.
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Puneral Director: After this certific completely filled in by the funeral director; p	Medical	one) 2 Medical Examiner: On the	e basis of examination and/or investigat anner stated.	ion, in my opinion, death	h occurred at the time, da	ate and place, and due to ti	ne cause(s)
H 3 H 5	ž	29b. Signature and title of certifier		29c. License num	ber	29d. Date signed (Mo	onth, Day, Year)
,		() 221	11	O.C.M.E.		January 29, 201	
1		30. Name and address of person who complet	ed cause of death (Item 22a)			,==,==	
Ψ		,	Medical Examiner 900 W. E	Baltimore Street R	Baltimore MD 2122	3	
9	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
Regis		JAN 3 1 2012 /2_	was D. parker				

OPIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ Farmer Bessie Mae Janua Medical 4c. County of Death Facility Name (if not institution, give street and number) Examiner tome 24 Hrs. 9. Birthplace (State or Foreign Country) North Caroli 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, 1 M 2 F Months Hours 91 Carolina Director 196-18-8458 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Harford Aberdeen 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 816 Paradise Road 21001 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillie Nichols William Preston Mayberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Road, Aberdeen, Maryland 21001 Larry Farmer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 2/04/20 Havre de Grace, MD 4 Donation 5 Other (Specify) Angel Hill Cemeter 22. Name and Address of Facility ature of Funeral Service Licenses Zellman Funeral Home, P.A. Washington St , Havre de Grace, MD 123 S. 23a Part 1. Enter the disease, or complice shock, or heart fallure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALOWAY disease or condition Medical resulting in death) Due to (or as a conseq en Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician anema Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown signed by the ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 within 24 hours after death. To the Funeral Director: After this certificate ☐ Yes 25. Was case referred to 26. Place of Death Check only one) Be examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1
Yes Certificate: 27, Manne of Deatl 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation 6 Could not be determined 3 Suicide 4 Homicide Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one 29b. Signature and title of certifier signed (Month, Day, Year)

Registrar

State

3

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 3:10 a.M Betty Ann Ferguson January 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford County Bel Air Brightview Assisted Living 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Min (Month, Day, Year) 76 219-30-4344 Director 1 🗆 M 2 🗶 F Aug. 27, 1935 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 ☐ Yes 2X No Maryland Harford County Bel Air 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 300 West Ring Factory Road, Apt. 121d 21014 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ori þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Post Office other traumatic event, the Mail Carrier other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h Lonnie C. Bottomley Thelma E. Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Vest (Son) 48 Jasmine Road, Delta, Pennsylvania17314 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo. Department of Important: If it any injury or o 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 1, 2012 Parkville, Maryland Parkwood Cemetery ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services-BelAir Acorn or Lym Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law page 2 s autopsy performed? Yes 2 No has certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ASSISTED.Ly 2 No Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \sum Yes 2 \sum No injury 1 💢 Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

within 24 hours after death.

To the Funeral Director: After Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, who completed cause of death (Item 23a) (Type, Print) Name and address of perso 742 SER 31. Date filed Month, Day, Year, State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 1 per dr., g923,01/31/2012dhb

Certificate of Death

Reg. No. Reg. No. 🗸 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Sadie F1eeks Physician/ Month 7:58 AM 2012 LZEKS ZLIZASETH 01 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL RALTIMORE RANDALLS TOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Hours Min **Director** 075-28-5436 1 □ M 2 🗹 F 7 04.03.1931 7 VA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director notified 1X Yes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number Examiner must be 23a Funeral 21117 U.S.A. 8712 Groffs Mill Drive items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 X Never Married 2 Married 0 ò 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates. Black 1 ☐ Yes 2 XNo Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Bureau of and Mental Hygiene. lementary/Secondary (0-12) College (1-4 or 5+) the Clerk Investigation na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Fleeks Mamie Cages 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Department of Health a Important; If item 27 is any injury or other tract Owings Mills, 8712 Groffs Mill Drive, Karen Williams-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State King Memorial Park 1/30/12 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) P Neral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION disease or condition resulting in death) minute Medical Due to (or as a consequence of) HIATAL year Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): -transit that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Dementic Hospital or Attending Physician: The law requires that the death certificate be as ed by the attending | detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

- Ph_sician/ Examiner

> page 2 should has

> > Be

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Certificate:

Medical

at er death.

Director: After this certificate I

Ji by the funeral director, pag

completely filled in by

24 hours a

within 2 To the F

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

Dementic

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
26. Place of Death (Check or	nly one)	

25. Was case referred to medical 2 No 1 Tes 27. Manner of Death

1 Natural

29a. Certifier

(Check

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at iniury work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

only one) B Certifying Nurse Practitioner: To the best of my knowledge, deat	th occurred at the time, date and place, and due to	the cause(s) and mann	er as stated
b. Signature and title of certifier	29c. License number	29d. Date	signed (Mo	onth, Day, Y
· / pall	DIFIFOOD	01	23	120

JAN

5 Pending

29d. Date signed (Month, Day, Year) -012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21, CROSS ROADS DRIVE, OWINGS SAMPATH SUBRAMANIAM 31. Date filed (Month, 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Season's Hospice **Baltimore** Randallstown 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Indiana Months Days Hours Min. 1 🗆 M 2 🗀 F (Manth Day 1963 189-58-6601 48 **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director notified 1 Yes 2 No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n Funeral 8811 Fearne Avenue 21234 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4 or 5+) 2 **Business Owner** 12 Construction event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of er traumatic ever ပ Donald James Rop Sharon Dawn Dunning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Davis / Husband 8811 Fearne Avenue, Parkville, MD 21234 Department of Healtl Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 1/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ una disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate rouse. E. ter chaerlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 morths?

1 Yes 2 No jo Month Day Year Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other 2 No ပ 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 🙋 Natural injury 5 Pending 2 No Accident Investigation 24 hours after death Funeral Director: filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) the 29b. Signature and title of certifier

State Registrar no completed cause of death (Item

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month 28, 2012 Physician/ 3:12 PM JANUARY JWEN DOLYN GILLIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** owson BALTIMORE SAINT JOSEPH MEDICAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs **Funeral** 213-58-3225 1 □ M 2 🛛 F 6 Yrs. 07-18-1950 Director NC 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State at Director notified BAUTIMORE 1 Yes 2 ☐ No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō pe Funeral USA 23a 21239 1426 MERIDENE DRIVE must 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE OF MARYLAND is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) OURT CLERK Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland 2 EdWARD WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, BALTO, MD . 21239 Department of Health ar Important: If item 27 is any injury or other trauonce. TERIJENE DAMEHTER YNNETTE 20b. Place of Disposition (Name of cemetery, crematory or other place)

ACK WOOD CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State BALTIMORE, MD 2/2/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FINEREN SENS 21. Signature Funeral Service Dicensee ROAD. BALTO, MO. 21212 YORK MO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final a ADULT RESPIRATORY DISTRESS SYNDROME Ph_sician/ disease or condition resulting in death) Medical Examiner SCHEMIC CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) RENAL Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PROGRESSIVE SCLEPODERMA 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ASPIRATION PNEUMONIA 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 Yes 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred I Director: After the funer 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) (Month, Day, Year) 29b. Sigr 35453 address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND M.D. OSLER DRIVE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, /Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 955 AM 2012 Month Physician John William Gryder January */Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Roland Park Place

. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F 569-24-6406 85 Director 11/6/1926 California Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 1∏Yes 2∏No Funeral Director Maryland N/A **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 830 W. 40th Street 21211 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ -3₩idowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemistry Professor Johns Hopkins University 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Thomas Gryder Myrtle Lieu Bogart ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Gryder / Son 2638 Bowling Green Drive, Vienna, <u>Virginia, 22180</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/30/2012 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3631 Falls Road, Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End-stage dementia ears **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if eny, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1☐ Yes 2☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ mass-under gussed 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2 3 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a **To t**he **Funeral L** 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical end manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, gregor 709 D Psubelle 013657 12huary 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. DABBLUE MACGREGOR, 830 W. 40 TH STREET, SALTIMONE, MD 21211 31. Date filed (Month, Day, Year) JAN 3 1 2012 32. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Bonnie Ghee .30P M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Seasons Hospice At Northwest Randallstown Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 11/14/1953 unk NY 1 □ M 2 🔀 F 58 Director 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Baltimore Windsor Mill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral items 23a 21244 USA 102 Longpine PL Apt 3B 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Aide Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ James Ghee Lelia Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Centre Mall Brooklyn NY 11231 Paul McLeod Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1/28/12 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 RidgeRD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ vulvular cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 - Nursing Home 5 - Residence 6 other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending s after death 2 Accident
3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MSROJAPANNIM.D 1127/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S RAMPARKIM D - 2835 Smr M N 5263 Baltimore MD 21209 N-S Rajapakseim.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 01 Physician/ Year 2012 10:06 AM Gary Wayne Gittere Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8545 Pulaski Highway, Lot 43 Rosedale **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Maryland Days Min (Month, Day, Year) 08/14/1949 1 X M 2 - F Months Hours Director 266-04-9078 62 Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits with the Maryland Director 1 X Yes 2 ☐ No MD Baltimore Rosedale 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 8545 Pulaski Highway, Lot 43 21237 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black White etc. "natural", or 1 Yes 2 X No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 XDivorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George William Gittere Dorothy Oleth Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Donovan / Sister 2330 Poplar Road, Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/28/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician teniosal disease or condition Y Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of, rany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the Unknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 🗆 Yes 2 🗀 No 3 🗆 Probably 🗚 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform rmed? 2 🗌 No 1 🔲 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director Be 1 Yes Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after de To the Funeral Directo completed filled in by th

4 \square Homicide

only one Sian

29a. Certifier (Check

Medical

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pleted cause of death (Item 23a (Type, Print) MD 6 wimb 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Zerman Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amy G. Greene 2012 1750 Jan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towsom Baltimore Gilchrist Hospice Care Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. I N. C Davs Hours 1 🗆 M 2 💭 ,193**8** 213-36-4060 73 **Director** Usual Residence of Decedent show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Towson 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 109 Kenilworth Park Drive Apt Funeral 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 Married Yes & No Yes, Give Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify 3 Widowed 4 Divorced Specify: Black Completed item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Unified District (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School System of CA. Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) : Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o William H. Grier Lillie Wed Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reeta Y. Buie (sister) 2332 BrightLeaf Way Balto, Md. 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge Cem. Feb.3,2012 Balto, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Strvice (Icen Calvin B. Scruggs Funeral Home 17412 E. Preston St. Balto.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Metastalie disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine ri any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPIC မ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Investigation within 24 hours after death

To the Funeral Director; A
completed filled in by the f Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and the of cert 29c. License number 29d. Date signed (Month, Day, Year, D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KINA

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32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 26, 2012 4:55 A Adolphe Thomas Gregoire Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 046-22-6668 **Director** 1 🛛 M 2 🗆 F December 8, 1928 83 Yrs Connecticut show 10d. Inside City Limits 10c. City, Town or Location 10a. State the Maryland notified at Director Rockville 1 X Yes 2 □ No 28a-f Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 20850 617 Northcliffe Drive United States items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 X Married þ White Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government the Scientist of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Adolphus Gregoire Euphemie St. Onge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Northcliffe Drive, Rockville, Maryland 20850 it of Health a Charlotte M. Gregoire/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. January 28, 1 Durial 2 X Cremation 3 Removal from State Department o Important: If any injury or ō Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Lice M01498 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Amyotrophic Lateral Sclerosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause E. tsl Grash, mg Cause (Disease or injury that initiated events Exami and the burial-tran Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: has page 2 after death.

Director: After this certificate 1 Yes 2 K No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 1 ☐ Yes 2 🔀 No မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b, Time of 28d. Describe how injury occurred Certificate: 1 🛭 Natural Accident 5 Pending the 1 Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide within 24 hours a

To the Funeral E

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signatice 29c. License number

- 1/ My

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20855

R143201

.26.12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:38PM Physician/ 2012 elores Hams Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Care - Od Randallstown Baltimbre Court Future 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 💢 F **Director** 80 Yrs. 19 or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shound injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No MD Windsor MIL 10e. Street and Number 10g. Citizen of What Country? USA 21244 Rogate Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (Erst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Martha Leech Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's ame/Relationship (Type, Print) Circle, Unit 102 Windsor Mill, MD James Harris Husbund, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Na)ne of 20c. Location - City or Town, State Date cemetery, crematory or other place)
odlawn Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Woodlawn, MD Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) Vaughon C. Greene Fureral services 21. Signature of Funeral Service License 22. Name and Address of Facility Road Pandallstown MD 21133 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, other failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ east disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the attending physician and thed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Dav 1 Yes 2 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Certificate: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c, Injury at 5 Pending Natural Accident work 2 🗌 No 1 Yes Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29d. Date signed (Month, Day, Year) MD 01/30/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) adds 14007a Kawa(C. 20) Crossroads Suite 101 Owings Mills MD21117 31. Date filed (Month, Day, Year)

JAN 3 1 2012 32. Registra State Registrar

elores

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January Harold 9:57 PM HODKIN 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death P.G. Capitol Hgts 505 Suffolk Avenue #313 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 88-28-1484 74 **Director** 1 ★ M 2 □ F 1-2-38 New York sidence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Capitol Hqts. MD. P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 U.S.A. 20743 505 Suffolk Ave. #313 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes Give 3★ Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Private Cosmetologist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Blonnie Williamson Harold Earl Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20743\,$ 505 Suffolk Ave. #306 Capitol Hgts. Md. Tony Hopkins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of h Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury (2/3/12 Suitland, Md. Washington Nat. 21. Signature of Funeral Service Licens 22. Name and Address of Facility

Hackett's Funeral Chapel, W. Hacket 814 Upshur Street, NW Fart 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23 V art 1. Approximate Interval Between erval Between set and Death **Ears** Immediate Cause (Final Physician/ Malignant weeplarn disease or condition resulting in death) Medical Due to (or a la consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hyper tenson 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The law Jas perform 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatı who completed cause of death (Item 23a) (Type, Print) 30. Name and anie State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ William Penfield Hume 7:33 A. M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** 7. Age (In vrs. last hirthday) June 2, 1942 Months Hours Georgia 69 Director 241-70-5417 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director or 28a-f sl e notified 1XXYes 2 ☐ No Millers Carroll MD 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code ms 23a or must be Funeral 21102 3607 Young Road America items 12. Was Decedent Ever in U.S. Armed Forces? 12. 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item ledical Examiner n 14. Race - American Indian, 11. Marital Status Black, White, etc. or permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examin ones. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: Year or Dates. Unk. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Electrical Engineer MVA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Amelia Brown Dr. John C. Hume 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Summerfelt-Hume (Wife) 3607 Young Rd., Millers, MD 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date All Faiths Crematory & Chapel 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Jan. 4 Donation 5 Other (Specify) 2012 Manchester, Maryland 21. Signature of Fun T Cervice License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, MD 21102 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failt Immediate Cause (Final ock, or heart failure. List only one cause on eat line. Physician/ disease or condition DEONAL Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed teusio n Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the b attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Ves 2 page certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to edical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work 1 Yes 2 No within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica Certifying hysician: To the be owledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical a control of the because of the cause [3 [only one) 29b. Signature c. License number 29d. Date signed (Month, Day, Year) 338486 2017 241 ro completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso. 814 31. Date filed (Month, Day, Year)s State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death I, Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 6:30 am January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore romwell enter Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours (Month, Day, Year) Director 243-36-4655 98 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho 10a, State Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 XYes 2 No MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21239 61619 Gleneagle Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore 8th grade <u>Day Care Provider</u> Ith and Mental Hygie 27 is marked other r traumatic event, ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Nathaniel Hansley Rebecca King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacque D. Law-Niece Gleneagle Road, Baltimore, Md 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 2/4/2012 Woodlawn, 21. Signature of Fune Marrend rider of Wells t 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/) ereki disease or condition) Medical Due to (or as | consequence of): resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner physician and s the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tyes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending Natural 2 🗌 No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident
Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 27,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkridge Md 21075 Marshal

State Registrar JAN 3 1 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 10/2 Medical not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death candalitto yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 85 **Director** 1 M 2 X F exas 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ✓ Yes 2 ☐ No TIMORE 0 10e. Street and Number 10g. Citizen of What Country? must be 23a Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Race - American Indian, Black, White, etc or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black "natural", 3 ₩Widowed 4 □ Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) daughtea 19b. Mailing Address (Street and Number or Rural Route Number, Kakembo 8612 DECRET Waves Way C 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place -7012 4 Donation 5 Other (Specify) RYCHOR Signature of Funeral Service Licensee 22. Name and Addre ellie & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ pt, D disease or condition resulting in death) Medical Examiner Dorch Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 this certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 2 No ၉ 1 Yes 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: Aft Natural М 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 06 79/9

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deceder t's Name (First, Middle, Last, 2. Date of Death 3. Time of Death :48PM Physician/ Month 10 Medical 4a, Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. BaIt., 1**X** M 2 □ Months Hours 10% 18/1927 Director 215-22-8749 MD 87 Usual Residence of Decedent 23a or 28a-f show 10a. State 72 hours after death with the Maryland be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **Examiner must** USA Aqua Place 21220 items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian o. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married 1X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Teamsters Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles M. Hauer Cecelia Klemm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Hauer - Wife 1034 Middlesex Road, Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 1/31/2012 Glen Burnie, MD Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Livensee 22. Name and Address of Facility 6224 Eastern Ave., Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a cous quence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy ło in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the detached Unknown 9 Unknown P.O. I signed by t Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 🗌 Yes Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Investigation 6 Could not be the . Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature/and title certifie 29c. License number 29d. Date signed (Month, Day, Year) S Y ess of person who completed cause of death (Item 23a) (Type, Print) 3 more

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Humphreys 2012 January 9:40 /Medical AM4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Home Crownsville Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/25/1938 **Funeral** 9. Birthplace (State or Foreign 1 XM 2□ F Days Hours 218-34-7285 Director 73 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mudical Examination of the properties of the proper 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 XYes 2 No Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 Fairfield Loop Road Funeral 21032 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xyes 2 Navy
1 Yes, Give Navy
Year or Datesty ietnam Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ğ 1 ☐ Yes 2XNo 3 XWidowed 4 ☐ Divorced Specify. Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Unkn. ٩ Unkn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Fiore / Social Worker 4 E. Rolling Crossroads, Ste 307, Baltimore, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/24/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Dorota Marshall \(\text{ClSke}\)Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma of the lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician a the burial-1 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1 ☐Yes 2 XNo Hospital or Attending Physician: **Director:** After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D38958 1/23/2012 the completed cause of death (Item 23a) (Type, Print) Da Geit Sidhu, MD, 208 Crain Hwy,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

SW, Glen Burnie, MD 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Relate of Markard 9962012 nettle of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28,2013 HEROLD MAROUARY 8:38 Medica! 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ISOHUSS UHA BALTIHORE-WASHINGTON MEDICAL CENTER GLEH BURNIE Social Security Number **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Country) Germany 1 □ M XX F 6/7/1924 220-38-9981 87 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Olen Drive 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2XXNo Maryland 21215-0036 1 Tes 2XXNo Specify: XX Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zwick Johann Bayerl Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karin Weaver 8016 Elizabeth Road Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Glen Haven Mem. Park 2/1/2012 Glen Burnie, MD 21. Signature A Funeral Ser e Linesee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MESENTERIC ISCHEMIA FMEEKS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No |은 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5

Registrar

DHMH 17 Rev 7/2009

State

Signature and title of certifier

31. Date filed (Month, Day, Year,

Quiconmissi ainer

GUILLERMO DOSE GIANGRECO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

11553000

301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161

JANUARY 28, 2012

Jerry Holloway 12-00508

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK 02298 State of Maryland / Department of Health and Mental Hygiene 2012 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1101 hrs Medical Examiner January 18, 2012 Jerry Holloway 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 5802 Annapolis Road, #601 Bladensburg 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Months Days Hours Director Country Maryland 1 × M 2 F Yrs 09/07/1960 Unkn. 51 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b Count 10c. City. Town or Location 1 Yes 2 No Prince George's Bladensburg permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23s or 23s-f she injury or other tramnatic event, the Medical Examiner, must be aptified at oace. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5208 Annapolis Road, #601 20710 USA Funera 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A Did Not Work 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latasha Pringle / Daughter 6001 Logan Way, Bladensburg, MD 20710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1/25/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall, i 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** een Onset and failure. List only one cause on each line. Medical Death a. Smoke inhalation and thermal injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate eques. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,27,28a-f,per me,g924 2-13-12 sm X UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 [signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>る</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? Yes 2 No 2 No 1 🗸 Yes Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical uneral director, å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other: Scene 1 Yes 28a. Date of Injury After 1 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification 1 Natural hours after death.

uneral Director: / fd 1-18-12 1 Yes 2 No Accidental house fire 5 Pending fd 10:53 am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) $5802 \ Annapolis \ Rd$ -Could not be Suicide Residence determined (Specify) 24 hours Homicide Bladensburg.Md. To the Host within 24 ho To the Functional Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 19, 2012 ause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 37. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPti,25,27,28a-f per me, g926,04/19/2012dhb Certificate of Death Reg. No for State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 1:30 Physician/ January 29, 2012 Ам Leslie Johnson, Jr. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Joseph Richey Hospice If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Hours Min (Month, Day, Year) **Director** 213-62-0554 1 **X** M 2 □ F DEC 19, 1975 36 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County at 10c. City, Town or Location Director Examiner must be notified 1 X Yes 2 □ No MD N/ABaltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ò 23a 1000 Shellbanks Road, Apt. Bl 21225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 9 þ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: "natural", **Black** 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Enterprise 12 Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 7 is marked o မ Felder Leslie Johnson, Angela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 21225 1000 Shellbanks RD., Apt. Bl Baltimore, MD Angela Johnson, mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 01/31/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 21228 202 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final -Physician/ weeks disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as consequence of) R Multiple Shotgun Wounds with Complications and resulting in death) Last -burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **N**o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn ☐ Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 X Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Hospital or Attending iniury **Editat**ural 5 Pending Subject was shot. 1 ☐ Yes 2X No 04/14/1997 2 Accident **12:09** a ^M within 24 hours after death

To the Funeral Director, of completely filled in by the Investigation 3 Suicide 4 M Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 800 Block of Jack Street, Baltimore City, MD determined Street Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) edler 2017

Registrar

DHMH 17 Rev 06-2011

State

NChates Street Baltimor Miss

o completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 aro 60 anuas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIN 10 7. Age (In yrs. last birthday) more 8. Date of Birth (Month, Day, Year, If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min **Director** 1 M 2 K 68 28a-f shov aţ 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗆 Yes 2 🔊 No perco ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a**Examiner must** or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Completed 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20b. Place of Disposition (Name of cemeter) crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Jan 28 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 16924 York Road, Mankton MD 21111 Signature of Funeral Service Licensee 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ DITOTORY Medical Due to (or as a consequence of Examiner mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No Month Dav Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has l performed? 2 🗌 No Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2**X** No မ Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier January RES-000 MD completed cause of death (Item 23a) (Type, Print) Raymono YUMG 31. Date filed (Month, Day, Year, State JAN31

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 28°, Physician/ 2012 0059A Charles Jackson, Jr. James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min 01-18-57 55 MI 362-64-0786 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 908 Laredo Drive 20901 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 M No Specify. Specify: American "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th Grade marked other than College (1-4 or 5+) uld be filed within Mental Hygiene. Self-employed Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Sr. Buzette Turner Jackson, James other traumatic should by and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health tem 27 i 4605 Horton Road Plant City, FL. Chandra Jackson-Wife item Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cem. 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 02 - 04 - 12Decatur, Ga. 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure Respiratory disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year been signed by the a should be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏋 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Left Atrial Thrombus 24a. Was an has autopsy page, performed? Yes 2 No certificate 1 🗌 Yes Yes I or Attending Physician: after death. ours after death.

Paral Director: After this certificalied in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) January 30, 2012 D66249

Registrar

DHMH 17 Rev 06-2011

Jonathan Duran, MD Holy Cross Hospital 1500 Forest Glen Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUAR 7:33PM Ruthi Jensen 2012 Medical 4c. County of Death Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner Me DICAL ALIIMORE LENTER 50 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 214-56-9170 **Director** 1 □ M 2 🕱 F 60 7/19/1951 Texas Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Baltimore 1 🗆 Yes 2 🗶 No Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 U.S.A 313 Limestone Valley Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical 2 years Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ injury or other traumatic James Suter Nellie Pate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trae Erik Jensen son 16819 Ridge Rd Upperco, MD 21155 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/28/2012 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Miller-Dippel Funeral Home gnature of Furriral Service Licenses Baltimore, MD 21206 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the dise shock, or heart failure or complicati t only one ca Approximate Interval Between NFARETON Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year signed by the at Id be detached for P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records. 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 🗔 ျှ 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day,

only one)

29b. Signature and title of certifier

30 Name and address of person who con

leted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) (01, 26, 12)

601 OSLER DRIVE TOWSON MD 21204

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 23°, 2012 Nora Helen Jason 6:35 P January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Days Min 091-28-0781 New York **Director** 1 M 2 X F 76 January 15, 1936 Usual Residence of Decedent 23/2012 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director Montgomery Village 1 Yes 2 No 28a-f Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 must be Funeral 23a 20886 9525 Duffer Way United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 X Never Married 2 Married 1 Yes If Yes, Give White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 - Widowed 4 - Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Federal Government Elementary/Secondary (0-12) Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ೭ Marion Zeh Stanley Jason ason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3 Magnolia Parkway, Chevy Chase, Maryland 20815 David D. Evans/Personal Representative 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State n. 29, 2012 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Jan. 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licensee M01498 Low 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician/ piratory Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe 1 ☐ Yes 2 X No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠No ျှ 1 Npatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1X Natural 5 Pending 1 Yes Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065505 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RockvillemD Fa Medical MD 9901 31. Date filed (Month, Day, 32. Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Item 25 Registrar	State of Ma per me,g	aryland / 923,01	/3072 Cer	rtment 2012di tificate	of H	lealth : Death	and M	ental Hy	giene _{Reg. No.} 2 (12	02304
Ï	Physicia Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yea								Year	3. Time of Death 2 30 PAM		
37 mg	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death UNIVERSITY of MARYLAND Baltimere							4c. County of Death N/A				
H	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Yes Months Day					Hours Min. 8. Date of Birth (Month, Day)					lace (State or Foreign try)
			Usual Residence of Decedent 10a, State 10b, County	IM Z L F	70 10c. City. To	Yrs.	ation				June 7,	1941		Zland Od. Inside City Limits
	laryland 3a-f sh iified a	ecto	Maryland Baltimo	re	3.	nkton								1 ☐ Yes 2 🛣 No
	h the N Sa or 23 be not	Funeral Director	10e. Street and Number				10f. Zip		111			10g. Citizen of		try?
	ems 2; ems 2; er must	uner	1034 Corbett Road 11. Marital Status	2. Was Decedent E	ver in U.S.	13. V	Vas Decede	nt of His	111 spanic Ori	gin? (Spec	ify Yes or No-	14. Rad	S.A. ce - Americ	
920	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 🗶 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 🕅 Yes 2 🗆 I If Yes, Give Year or Dates 1			Yes, specif				ican, etc.)		ck, White, 6	
21215-0036	72 hour	Completed	15. Decedent's Edu (Specify only highest grade	e completed)		(Give k	ent's Usual and of work NOT use i	done d	ation luring mos	t of workin	g	16b. Kind of B	usiness/Ind	dustry
212	led within Hygiene. other thar ent, the M		Elementary/Secondary (0-12)	5+ years	+)	ille. Do	Phys		an			Med	lical	
	be filed intal Hy ced oth cevent	To Be	17. Father's Name (First, Middle, Last) Raymond Edgar Know	alog Sr					18. Moth	er's Name	(First, Middle, Lacch	Maiden Sumam ni	e)	
Maryland	e 1 and 2 should be filed within 72 hours after death with the Maryland to f Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ff item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type	e, Print)	111				and Numb		Route Numbe	r, City or Town,		
			Dennis T. Knowles 20a. Method of Disposition	(brothe	, ' 		Corbe		Road		ton, M	aryland 20c. Location		
mor	0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donaţion 5 🏋 Other (Specify)		ceme	tery, cren v Val	natory or oth Lev Men	her plac n. Gr	dns. 1	Maus.	1-27-12	Timoni	um, M	aryland
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee			22 M	Name and itche	Addres 11-V York	ss of Facili Viede K Roa	feld d Ba	Funera ltimor	1 Home, e, Mary	Inc. land	21212
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused cause on each line	the death. Do	o not ente	r the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
Si.	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence	e of):	A						-	
	Examiner	J.	Sequentially list conditions	Progressive Ascending Paralysis Due to for as a consequence of):										
	ecuted and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a	onsequenc	e ot):					11	//_		
	e execu cian and ourial-tra	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):			0	M	D'BY MEDICAL	EXAMINER		
190	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Nedical		1.				CE	RTIFICATIO	MAPPROV				
Box 687		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								ate of deliv onth	ery Day Year		
ls, P.O.												ne cause of death?		
Records,		Completed by		-							24a. Was auto perfo 1 Yes		Were auto prior to co death? 1 Yes	psy findings available impletion of cause of 2 No
/ital	rsician: s certific director	To Be	25. Was case referred to medical examiner?	ospital:	ent 2 \square EB/	(Outpatier	nt 3 🗆 DO	Othe	or:	ath <i>(Check</i> lursing Ho		dence 6 🗆 Oth	ner (Specify	0
) of	ling Phy I. After this funeral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work?										
Division of Vital	or Attendi fter death irector: A in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				_	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospital 24 hours a Funeral I stely filled	Medical (29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	er: On the basis of e	xamination and	d/or inves	tigation, in n	ny oninio	on, death c	occurred at	the time, date	and place, and d	ue to the ca	use(s) and manner stated.
4	To the within To the comple	Σ	29b. Signature and title of certifier	1 / C			29c.	License	e number			29d. Date sign		
			185%	M)	-) /T		128	359	238	62	1/2	3/12	
121	1		30. Name and address of person who co	22 N.Hon	eath (Item 23a	SA/	Print) Ref	Ba	ltimo	S 2 :	MD	2120,	/	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 3 0 2012	32. Registra	ar's Signature		Val.							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O) Physician/ 1750 Frank Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Aconde Anne Hrunde Annapalis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 191-16-8102 Director 1 X M 2 □ F 87 DEC 18, 1924 Pennsylvania Usual Residence of Deceden 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Tes 2 No MD Anne Arundel Annapolis 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 940 Astern Way, Unit 409 21401 USA items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Completed 1945-50 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Commercial Sales Industrial Insulation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Kane Marion Landy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Kane, wife 940 Astern Way, Unit 409 Annapolis. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 01/31/12 Baltimore, George MacNabb 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Renal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HTW Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law equires thin 24 hours after death.

the Funeral Director: After this certificate has been sign Mass 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ patient 2 ER/Outpatient 3 DOA filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 Yes 2 No Investigation Accident
Suicide
Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Convirging Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 within To the 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

2001 Medical

cause of death (Item 23a) (Type, Print)

40052624

Annapolis

12-00630 Thelma Keen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 02306

			- For State Registrar		Certif	icate of l	Death				. No.	
	Physicia		Decedent's Name (First, Mide	dle,Lest)					2.	Date of Death Month	Day Yeer	3. Time of Death
Medic	cal Exami	ner	Thelma Loui	se Keen						January 23		0418 hrs
			4a. Facility Name (if not instituti	on, give street and num	ber)	4b	. City, Town, o	r Location of	Death		4c. County of	Death
			Upper Chesapeake N	Medical Center			Bel Air				Harford	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last	birthday)	If Under 1 Yea	_	_	8. Date of 8irth		Birthplace (State or Foreign
	Director		216 05 2726	1 M 2 F	9	C Yrs.	Months Day	ys Hours	Min.	07/16		Country)Maryland
		-	216-05-3726 Usual Residence of Decedent		9	Z				07710	1010	ilar y rain
	ĥi e		10a. Stete 10b. County		10c. City, To	wn or Location	n					10d. Inside City Limits
	E					По		1				1 Yes 2 No
	ylanc -f sh	흲	MD H	larford			st Hil 10f.ZipCode	<u>- </u>		100	. Citizen of Wha	at Country?
	ne Maryland or 28a-f show fied at once.	Director	TOE. Street and Number				Ton. Zip codo				,	
	hours after death with the Maryland "natural", or items 13a or 28a-f sho Examiner must be notified at once		201 Colgate	Drive				21050				S.A.
	be n	Funeral	11. Marital Status	1	dent Ever in U.S. ces?		Decedent of His, specify Cuba				14. Race - White,	American Indian, Black, etc.
	deatl	들	1 Never Married 2 N	1 Yes	2 X No		_					White
	after after	Ā	94-	vorced If Yes, Give Year or Dates:			es 2 X No					
	filed within 72 hours after Hygiene. d other than "natural", (٦	15. Decedent's Education (Sp.	ecify only highest grade	completed) 16		s Usual Occupa st of working life				16b. Kind of Bus	iness/Industry
.,		Completed	Elementary/Secondary (0-12) College (1-4	or 5+)		•			·		
2	Et P. B. iti	剈	12]		M	anager	-				<u>ician Office</u>
S	Hygiene.	ड	17. Father's Name (First, Middle	e, Last)				18.Mother's	Name (F	First, Middle, Ma	aiden Surname)	
24	be fill	Be	Charles Bag	gent _						Goniga		
2	ould I Me	٩	19a. Informant's Name/Relation	ship (Type, Print)	1	19b. Mailing	Address (Stre	et and Numb	er or Ru	ral Route Numb	er, City or Town	, State, Zip Code)
WIN 24245_0036	12 should be file th and Mental H 27 is marked of umatic event, til		Russell Keer	(Son)		5010	Woods	Line	Dr.	,Aber	deen, 1	MD 21001
9	Treat and		20a. Method of Disposition		L L	ce of Dispositi matory or othe	ion (Name of ce	emetery,		Date	20c. Location - (City or Town, State
Š	Pages I and 2 should be fill ment of Health and Mental lant: If item 27 is marked or other traumatic event,		1 Burial 2 X Crematic		II State	-	-	Tnd	1/2	7/201	2 W Ch	ester. PA
o-cuiting D	rtme P	1	Donation 5 Other 5	e Licensee	IKA	22. Na	me and Addres	ss of Facility	701	llman	Funera	ester, PA l Home, P.A.
å	Dermit. Pages 1 and 2 s Department of Health a Important: If item 27	1	March C	2000	MAN.							de Grace, MD
	Physician	H	23a. Pert I. Enter the disease, of	or complications that cau	used the death. Do	o not enter the	mode of dying	g, such as ca	rdiac or r	espiratory erre	st, shock, or hea	rt Approximate Interval
	/Medicai		failure. List only one caus	e on each line.								Between Onset and Death
	Examiner		Immediate Cause (Finel diseas or condition resulting in death)		onsequence of):				_			
		_		h	onocquonoc enj.							
		ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):							
		틝	cause. Enter Underlying Cause	C.		_						
	sit d	Ξ.	events resulting in death) Last Due to (or as a consequence of):									
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-	ਰ ਜ਼ੁਥ	Medical	UNPENDED	AMENDED								
760	r ou, cate be ex physician the burial	Ž.	IF FEMALE: 23b. Was decedent pregnent in		utcome of pregnar				Unition.		23d. Date of o	delivery Day Year
0	certific r certific tending puse as t	<u>ia</u>	past 12 months?	I LIVE BII	th nt at time of death	2 Feta		Ectopic	pregnanc	Су	Month	Day You
09 200	leath certifi e attending for use as	Physician	1 Yes 2 ✔ No 9 U	nknown 9 Unknow		5 Oth	er (Specify)				1	
	the d	돈	Part II. Other significant cond			ulting in the un	derlying cause	given in Par	t 1.	23e, Did tob	acco use contrib	oute to the cause of death?
0	that ned b	Ď	922	•						1 Yes	2 ✔ No 3	Probably 4 Unknown
3	w requires t w requires t is been sign should be c	ted								24a. Was a	n 24b. W	Vere autopsy findings available
7	w rec	Completed								autops perform		nor to completion of cause of eath?
Š	ician: The lav ician: The lav certificate har rector, page 2	E								1 Yes 2		
-	cal Ke		25. Was case referred to medic				26.Plac	ce of Death (
1.6	VICE ysicis his ce direct	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 🗸 In	patient 2 🔲 El	R/Outpatient	3 DOA	Other ₄	Nursing	Home 5 F	Residence 6	Other:
5	ing Ph After th	5	27. Manner of Death	28a. Date of	f Injury 2	8b. Time of In	jury 28c. In	jury at Work?			ow injury occurre	ed
9	ith. Te fur	힕		nding FOUND: pestigation Jan 16, 2		OUND: 1000 hrs	1	Yes 2	No S	Subject fell		
	Afte ar dea recto by th	<u> </u>		28e Place	of Injury - At hom		, factory, office	building, etc	: 2			er or Rural Route Number, City
č	LIVISION OF VIZI RECOLDS, F.O. Is or Attending Physician: The law requires that the last clearly. After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	del	uld not be termined (Specify)	Assisted Livi	ng Facility			1	or Town, St Colgate Drive	ate) e, Forest Hill, I	MD
	Tospi 4 hou uner		29a. Certifier	Physician: To the hest	of my knowledge	death occurr	ed at the time.	date and pla	ce, and d	lue to the cause	e(s) and manner	as stated.
	LIVISION OF VIZIL RECORDS, P.O. BOX 80. To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. Within 24 hours after death. Within Percara Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	Medicai	(Check only one) 2 ✓ Medical Ex	caminer: On the basis of	examination and	or investigation	on, in my opinio	on, death occ	curred at	the time, date a	and place, and di	ue to the cause(s)
	To with	Med	29b. Signature and title of certi	and manner sta	ated			nse number				ed (Month, Day, Year)
			1 1	11/2/1/ 2018			0.0	C.M.E.			January 24	, 2012
	7		Husielle Viction, MI)									
1.	/		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223									
l					istrar's Signature							
		tate trar	31. Date filed (Month, Day, Yea	L Centra	1. 10	ENCO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Certificate of Death Reg. No. 1 Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ Month KINGSBURY KENNETH **GARNER** 2012 ANUARY 9:11 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7001 HASTING DRIVE PRINCE GEORGE'S CAPITOL HEIGHTS Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Davs Months Hours JULY 29 Year 1933 WASHINGTON, DC 579-48-3800 Director 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Examiner must be notified PRINCE GEORGE'S MARYLAND CAPITOL HEIGHTS 1 X Yes 2 No ō 10f. Zip Code 10g. Citizen of What Country? 7001 HASTING DRIVE 20743 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
In act at If item 27 is marked other than "natural", or items in vinjuy or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces TXYes 2 No**POST**—Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates. -- KOREAN BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) **9TH** College (1-4 or 5+) TRUCK DRIVER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည KINGSBURY **EVA** CHANDLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA BARNES / DAUGHTER 7001 HASTING DRIVE, CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 2/8/2012 CHELTENHAM, MARYLAND 21. Signature of Experal Seri 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSCLEROTIC HEART DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ESSENTIAL HYPERTENSION Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed MORBID OBESITY Due to (or as a consequence of) resulting in death) Last buriat-Physician/Medical Box 68760 the attending pl IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes မ 2 No 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Tes 2 No Accident Investigation after death Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD# 0101227815 Ohners JANUARY 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JOANNA BRYNN ROSEN, MD, VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 25, 2012 11:55A M Physician/ Margaret Elizabeth Kuemmel Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Sept Da 2 791, 1918 Hours Ballimore, MD 213-01-6431 93 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Parkville Baltimore 1 Yes 2 X No 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 21234 items 23a 7 Dakin Court United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc ъ þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify. White If Yes. Give Completed 3 XWidowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. At Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Appel 17. Father's Name (First, Middle, Last) ပ Charles Kuhl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dakin Court Parkville, MD 21234 John Kuemmel, II-Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of January 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MoreTand Memorial Parkville, 28, 4 Donation 5 Other (Specify) 2012 Park 21. Signature of Funeral Service License 22 Name and Address of Faculty Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death ediate Cause (Final Physician/ ase or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Stroke Records, 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🔲 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO 3 DLCC 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral (28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural Investigation Accident after deat Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide determined hin 24 hours after the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

within 2 **To the F**

(Check

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WO

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

N. Charles ST

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4:45 AM Vcosi Sa **Physician** alter 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City FutureCare- Canton Harbor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 ₹ M 2 □ F 81 212-26-7957 00 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Podical Experient must be notified at 1 ☐Yes 2 No Director Dunda1k Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 U.S.A. 7129 Railway Avenue Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Elementary/Secondary (0-12) College (1-4or 5+) Brewing Company Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maryanna Blachowicz Kosiba George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7129 Railway Avenue Baltimore, Md. 21222 Gloria Kosiba / Wife 20c. Location - City or Town, State February 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cem: 22. Name and Address of Facility Kaczorowski Funeral Home, PA Signature of Funer V Service Licensee M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Hyper know As testoscloustic Corner Use to (or as a consequence of): **Physician** resulting in death) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Der Hospital or Attending Physician: The law requires that the death certificate be executed Exami sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jimknown Anylord ango pechy Completed 24b. Were autopsy findings available prior to completion of cause of death? ald colon cancer 24a. Was an autopsy performed certificate old no texte courses 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 LAK 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D19667 01-29-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Qtries Hipways 508 Cla Bries, Mayland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 for State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 January 28. Richard R. Lyskawa 7:30РМ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5117 West Running Brook Road Columbia Howard 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 2 8. Date of Birth **Funeral** Months Min. (Month, Day, Year) Hours 387-26-2896 Director 1 🔀 M 2 🗆 F 81 1930 May 28. Wisconsin Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director notified 28a-f 1 🗌 Yes 2 🎇 No MD Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 10 Roseneath Court 20832 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 X Married 1 \overline{X} Yes 2 \square No If Yes, Give Year or Dates. 1948-52permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: 'natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Offset Printer 27 is marked other r traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and Mental Max Lyskawa Stella 3 4 1 Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olney, Johanna L. Lyskawa, wife 10 Roseneath Court 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 XCremation 3 Removal from State Metro Crematory, Inc. 01/30/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) MacNabb 22. Name and Address of Facility 21. Signature of Funeral Service Licensee George Cremation Society of MD. Inc. Leos 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph_sician/ END STAGE disease or condition resulting in death) Medical **Examiner** ORONARY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) SON 5 HOME 2 🔀 No ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

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DANIEUE DOBERMAN, MD

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CEDAR LANE

29d. Date signed (Month, Day, Year)

COLUMBIA, MD 21044

JANUARY 30, 2012

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		-	For State Registrar	Otate of Marylan		te of Death	Reg. No. 2012 02311			
Г	*		1. Decedent's Name (First, Middle, Last)				2. Date of Death 3. Time of Death			
Ž.	Physicia Medic	al	ROBERT J	128			Month 1	25 2012 04301		
	Examin		4a. Facility Name (if not institution, give st UNION MEMOR	IALHOSPITH	AL B	ALTIMORE	MD	4c. County of Death		
*	Funeral Director		1 1 2 2 2	7. Age (In yrs. la	Months Yrs.	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,)	9. Birthplace (State or Foreign Country) 943 North Carolina		
	and show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Location		11111	10d. Inside City Limits		
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland NIA		Bai-	timore		1 M Yes 2 □ No		
	vith the	eral [10e. Street and Number	4 7 20	de12 101.2	DIDZG	10	Og. Citizen of What Country?		
	leath v	Funeral	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	3. 13. Was Dece	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.		
36	after c	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		2 ☑ No Specify:		Specify: D		
9-0	hours natura dical E	lete	15. Decedent's Edu		16a. Decedent's Us	ual Occupation ork done during most of work	ving 1	16b. Kind of Business/Industry		
21215-0036	within 72 giene. her than " t, the Mec	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT us		T.	Distr Association		
	led wit Hygie other ent, th		17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)		
Maryland	ld be fi Mental larked atic ev	은	Robert Jan	nes Lea	e Sr.	Es+	her_	Terrell		
Man	shoul h and I 7 is m rraum		19a. Informant's Name/Relationship (Type	1.75	19b. Mailing Addre	ss (Street and Number or Rur	al Route Number, C	City or Town, State, Zip Code)		
e)	f Healt f Healt item 2 other		20a. Method of Disposition		lace of Disposition (Na		Date 2	20c. Location - City or Town, State		
mo	Page 1		†	lemoval from State	emetery, crematory or	enater 28	12012]	Dundalk-MD		
Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licenset	ale 4	Marie 22 Marie	nd Address Facility	3 Thinks			
	402.00		23a. Part 1. Enter the disease, or compli	cations that caused the death	h. Do not enter the mo	de of dying, such as cardiac	or respiratory arres	Baita: MD 21a16		
L.	newictan/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.		issosis		Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequ		The ♥ (My table) The straight (
	Lammer	er	Sequentially list conditions, if any, leading to immediate		uence of);					
٠٨.	executed in and ial-transit	Examine	ause. Enter Underlying Cause (Disease or injury that initiated events C							
	ω ω Ξ		resulting in death) Last	Due to (or as a consequ	uence of):					
09/	or Attending Physician; The law requires that the death certificate be enter death certificate be enter death care this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the bur	edic								
89	certific inding use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta		programov		23d. Date of delivery		
Вох	death he atte ed for	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of c			Month Day Year			
P.O. Box 68760	at the ed by ti detach		Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?		
IS, F	uires th	Completed by	COPD, HIV, Dy	clydeme	tes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow				
Sorc	aw req	plet			- <u>-</u>		24a. Was an	prior to completion of cause of		
Re	sician; The law r certificate has b director, page 2 s					performed? death? 1 Yes 2 No 1 Yes 2 No				
lital	sician certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	26. Place of Death (Chec ant 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			nce 6 Other (Specify)		
of \	g Physical this neral di	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred			
ion	or Attending after death. Director: After in by the fune	ifica	Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		M	1 ☐ Yes 2 ☐ No				
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certificate:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		лу, опісе		ation (Street and Number or Rural Route Number, or Town, State)		
	e Hospital		(Check 2 Medical Examination	cian: To the best of my know er: On the basis of examination Practitioner: To the best of r	n and/or investigation, i	n my opinion, death occurred a	at the time, date and	se(s) and manner as stated. d place, and due to the cause(s) and manner stated. e cause(s) and manner as stated.		
	To the within 2 To the I		29b. Signature and title of certifier			c. License number	29	9d. Date signed (Month, Day, Year)		
	- 2		meanape		220) (T D.1.1)	D70031		01/25/12		
	3		30. Name and address of person who co VRINDA MAHATAN 31. Date filed (Month, Day, Year)	mpleted cause of death (Item J 201 E. UNIV	ERSITY RA	RKWAY, BALTI	MORE M	D 21218		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 2 1 - State of Maryland / Department of Health and Mental Hygiene 2 0 Per dr., g923,01/31/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Elizabe 15:05 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ARTORD If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Min Months Hours 212-10-0680 Maryland Yrs Director Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Tes 2 X No Bel Air MD Harford 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 21014 128 W. Ring Factory Rd; Apt 129 items 2 permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hyglene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T 12 procurement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Mary Wisbeck Edward Aloysius Hogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1119 Chatelaine Dr; Fallston, MD 21047 19a. Informant's Name/Relationship (Type, Print) Barry G. Little - son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Ronal 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any hading to cause. Enter Underlying Examine Due to jor as a consequence of Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: If the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the bast of/my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ekunda Alade, M.D., 500 Upper Chesapeake Drive, Bel Air, MD 21014 22. Registrar's Signature State Cerem

DHMH 17 Rev 7/2009

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar 02313 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CONC 78 **₽** M 1:38 583015 Medical lanuari 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saltimore Washinaton Medica Anne Arunde urnie If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) XX M 2 🗆 Days Hours 282-28-9938 75 10/3/1936 **Director** MD Usual Residence of Decedent 28a-f shov 10a, State with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes XXX No MD Anne Arundel Glen Burnie 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1302 Aster Drive 21061 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forces Black, White, etc. by 1 Never Married XX Married 9 XX Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Command Sgt. Major US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Lewis G. Long, Sr. Elizabeth Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Mrs. Jean M. Long / Wife Glen Burnie, MD 21061 1302 Aster Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) UNKNOWN Arlington National Arlington, VA 21. Signature of un ral Servi Linux, e 22. Name and Address of Facility Singleton Funeral & Cremation 0 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) MateM NEEK Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Year Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD, HTH, DHZ 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 2 4 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 L inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

GUILLERMO JOSÉ GIANCRECO 31. Date filed (Month, Day, Year)

JAN 3 1 2012

an conficient or completes MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

301 HOSPITAL DRIVE, BLEW BURNIE, MD 20161

DHMH 17 Rev 7/2009

29c. License number

10065+14

29d. Date signed (Month, Day, Year)

24HUARY 28,2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ RUTH LOWE 01.07AM 2012 Jan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner orth West Hospital Randallstown Baltimore 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday If Under 1 Year **Funeral** Months N°Carolina 160/29 / 1929 215-24-7073 82 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No MD N/A Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 items 23a or ner must be n Funeral 330 N. Carrollton Ave. 21223 . A 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black "natural", Completed 3 ₩ Widowed 4 □ Divorced Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' 10th Grade College (1-4 or 5+) the Seamstress Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Meddley Abbie Jones other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Jones(sister) Carrollton Ave., Baltimore, MD21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Druid Ridge 02/02/12 Baltimore, MD Joseph H. Brown Jr. Funeral Home PA 21. Signature of Funeral Service Licenses 2140 N. Fulton Ave., MD2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) BYBNOYY Medical Due to (or as a consequence of) Examiner Sta Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to for as a consequ Exami Hnemia To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 q guibr as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the detached 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be det by 2 No 3 Probably 4 🗷 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed death? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d Describe how injury occurred iniury Natural 5 \square Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Christia

Nallu

MP

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwest

DHMH 17 Rev 7/2009

Hospital

32. Registrar's Signature

D 67325

5401, Old Court Rd, Randallstown

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January ²25 2012 6:10 p_M Katherine MacKenzie Medical 4a. Facility Name (if not institution, give street and number) Greater Baltimore Medical Center Towson **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 213-52-5480 **Director** 1 🗆 M 2 😾 F May 17, 1941 70 Maryland 28a-f shov Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2903 Willoughby Beach Road 21040 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian MACKEN PLO LOT ALL SOLUTION SE Altimore, Maryland 21215-0036 Armed Forces þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ William Albert Suter, Sr. Nellie Helen Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Page 1 and 2 sh tment of Health a tant: If item 27 is Dawn Stefanik / Daughter 2903 Willoughby Beach Rd., Edgewood, MD 21040 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 01/27/2012 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Peritonitis Immediate Cause (Final Physician/ 3 day disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ancy to penia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 № 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N Charler Sf Susse Towson 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Kenneth Allen Maylath 11:54 AM JANUARY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE OSEDALE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 18, 1936 1 X M 2 - F Days Hours New York 128-28-9960 75 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 🗆 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2915 Church Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Radio Station permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important; If item 27 is marked other the any injury or other traumatic event, the I News Broadcaster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth G. Fehling Lester Maylath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2915 Church Road Parkville, MD 21234 John Phillips- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, MD 3, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Evans funefall Chapel & Cremation Services 8800 Harford Rd. Parkville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. ediate Cause (Final SEPSIS Onset and Death Physician/ ease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy performed this certificate Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 1 🗌 Yes 2 🔲 No 24 hours after death. e Funeral Director: A bleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 55034 1-30-2012

State Registrar 30. Name and address of

JACQUES R. C

DHMH 17 Rev 7/2009

9000 FRANKLIN SQUARE DRIVE BALTIMORE MD. 21237

son who completed cause of death (Item 23a) (Type, Print)

MD

R. CONAWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mc Caffery Physician/ 0236 AM anvar Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner OKINS salt more If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** (Month, Day, Year) Jan 10, 1944 Months Hours 68 Director Pennsylvania 181-34-7506 1 🗆 M 2 💢 F 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2143 Sandcastle Ct 21403 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 0 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. 'natural", 3 Widowed 4 Divorced White Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Motivational Speaker Consultant event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Page 1 and 2 should be Francis Girard Aloysious Carroll Anne Loretta Lally and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mary N. Heffner /Sister 2143 Sandcastle Ct Annapolis, MD 21403 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State of Important: If i 1 Burial 2 Cremation 3 Removal from State Jan 30 Beltsville, Maryland 4 Donation 5 Other (Specify) 2012 Chesapeake Crematory Signature of Funeral Service Licensee 22. Narchard Sof Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Mitalvalve ⊮nysician/ disease or condition resulting in death) Medical **Examiner** Pneuma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ detached for Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death ☐ Yes _ _ ☐ Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Be Completed by pe 3 Probably 4 Unknown 1 Yes No page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has I autopsy perform Yes 2 death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital ပ 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one 29b. Signature and title of c RCS- 000 MI ed cause of death (Item 23a) (Type, Print) 30 Name and

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, per FH, G924, 2/16/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 2012 20 812 McQueen L. Maggie Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Country Months 238-48-8611 Director 1 □ M 2 🔀 F 75 NC 02/02/1936 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location aţ 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20910 733 Sligo Ave. #410 death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: Black Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Care Elementary/Secondary (0-12) College (1-4 or 5+) Howard University Day Child Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည E. Lilly Lightfoot Viola Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 733 Sligo Ave. #410 Silver Spring, MD 20910 Beverly Cooper/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Fort Lincoln Cemetery, O2/03/2012 1 X Burial 2 Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition resulting in death) Acute Renal Failure years Medical Due to (or as a consequence of): Examiner Severe Metabolic Acidosis day Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of hours Cardiac Arrythmias and -tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a the for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Dav Pregnant at time of death 1 Yes 2 9 Unknown Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? Yes 2 No certificate has page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending М Accide Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) annaz D50987 up 1-23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest glen and Silver Spring mo 20910.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 26,2012° Margaret Virginia Michael 9:35P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Balto. Social Security Number 6. Sex Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 212-32-9983 76 **Director** 1 🗆 M 2 🔀 F June 15,1935 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Md. Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a 615 Lanark Court 21015 11SA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes Yes, Give 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Secretary Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James F. Quigley Margaret F. Cadden Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 and 2 bepartment of Health John J. Michael, Jr. 615 Lanark Court Bel Air, Md,. 21015 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sacred Heart of Jesus 1-31-2012 Dundalk, Md. 4 Defiation 5 Other (Specify) Schimunek Funeral Home of BelAir 21. Signatur of Funeral Servi Licen 22. Name and Address of Facility 610 W. MacPhail Road Bel Air, Md. 21014 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed 2 X No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending

Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death

р.ш.

9:38

Maryland

Baltimore,

Registrar

JACKIE JONES,

2 Accident
3 Suicide
4 Homicide

29a. Certifier

(Check

only one) 29b. Signature ar

Investigation 6 Could not be

determined

of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. CRNP

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2012

32. Registrar's Signatur

M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast 2 Date of Death Physician/ Month 20 a M Mary Elizabeth Macri Medical 4a. Facility Name (if not institution, give street and number) Examiner Balti more 20 uare 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 219-14-1198 **Director** 1 🗆 M 2 🔀 F 86 04/06/1925 MD 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at **Funeral Director** Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5935 Clayton Avenue U.S.A 21206 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Amer. Vets the Telemarketer 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Henneke Charles Kimmarle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5935 Clayton Avenue Baltimore, MD 21206 <u>Michael Macri</u> son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Dul. Valley Mem. Gar. 01/31/2012 Timonium, MD any inj Signatui 22. Name and Address of Facility Miller-Dippel Funeral Home Tre a Fervi Lice see 6415 Belair Rd Baltimore, MD 21206 rt 1. Enter the disease, of complications that only one cause on ea death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Preparations) Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 🔲 Yes 2 🗌 No after death. Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) Frankli nsquare

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 945 AM John Anthony McDermott 2012 2 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosedale Baltimore FRANKLIN SQUARE HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06/13/1937 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F Maryland 74 218-34-0289 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 9441 Seven Courts Drive 21236 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □Yes 2 □ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Business 12th Roofing Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William C. McDermott Emma Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9441 Seven Courts Dr., Nottingham, MD 21236 Margie McDermott 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem'l Gardens 1/31/2012 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc., 21. Signature of Funeral Service Lieensee 9705 Belair Rd., Nottingham, MD 23a. Part 1. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) (STAG Esopha Cancer E Ce Due to (or as a construence of): Due to for as a conse mence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner**

Physician

Examiner

Director

Funeral

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Completed

Be

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

attending physician and for use as the burial-trar Physician/Medical been signed by the should be detached

24 hours after death.

9 Funeral Director: After this certificate has letely filled in by the funeral director, page 2 s

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hou

To the Fune

completely fi

Registrar

State

Sequentially list conditions, if any, each of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

yamour, MO, PHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FAANKLIN Square DR Balto md Janvier

29c. License number Doorois& 29d. Date signed (Month, Day, Year)

1/27/12

PR Adrien
31. Date filed (Month, Day, Year)
11. 31. 2012

29b. Signature and title of certifier

32. Registrar's Si nature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28^y 2012 7:05 John Wesley Maddox A M Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice **Timonium** Baltimore 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 D F 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days (M05/30/1961 50 Maryland UNKN. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6809 Columbia Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Marital Status Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify "natural" 3 Widowed 4X Divorced Completed White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Lineman Manufacture 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Maddox Rosemary Neff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once. 33 Waterview Road, Baltimore, MD 21222 Bonnie Jo Lambdin / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burial 2- Cremation 3 ☐ Removal from State Chesapeake Crematory 1/30/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as. IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 1 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 Other: Min မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? Natural 5 Pending injury 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d Date signed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G924 2/09/2012 TH Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27,2°012 Physician/ Mitchell 5:50PM Mary Α. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Genesis Eldercare- Heritage If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 216-36-2735 1 □ M 2 □XF December 1,1937 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21222 131 Willow Spring Road Apt 1B 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 **X** No If Yes, Give Completed by Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 3 XXidowed 4 □ Divorced Specify. Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 years Cleaner **JAnitorial** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethal S. Hurley Herman R. Neeper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Perseghin Daughter 7902 Stratman Road, Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 30, 2012 21. Signature of Funeral Serv ²² Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ALUDENT Ph_sician/ disease or condition resulting in death) Medical **Examiner** VASHILAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine DYSPHAGIA ding physician and use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant for us 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No Yes within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other 1 🗌 Yes 2 No. မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) Place Dundalk MD 21222 2 Market 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Physician/ Lauren Faith Medcalf 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dr. Bob's Place Baltimore Baltimore City 5. Social Security Number ukn 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Davs Min 1 □ M 2 🕱 F Director 01/25/2012 MD Usual Residence of Dec iner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo MD Linthicum Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 450 Gayle Drive 21090 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Black Completed Year or Dates 2 event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 Elementary/Secondary (0-12) College (1-4 or 5+) ME 0 Dependent Dependent other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever should be John Randolph Medcalf Ivy Rochelle Mooring 子ろの 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linthicum, Maryland 21090 Mrs. Ivy R. Medcalf / mother Gayle Drive, Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD MO1357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ risomu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injurthat initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached g Unknown n signed by the sid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 LINO hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) pletely filled in by the funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined HREN Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 056211

State Registrar

DHMH 17 Rev 06-2011

MEDCAL

LAUREN

3001 5. Harover St. F. Zrwin 31. Date filed (Month, Day, Year)

JAN 3 1 2012 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

, mo

Baltimore, mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1033AM tevin Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min (Month, Day, Year) 217-48-7781 **Director** 1 🔀 M 2 🗆 F 51 Yrs. 1960 Maryland Nov 20, Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d, Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2X No Anne Arundel Annapolis Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21.401 USA 2610 Rigging Drive iral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 ☐ Married within 72 hours after 1 Yes 2 No Specify. Specify: White Completed I "natural", 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Bingo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ Morris Needle Helen Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 i 2610 Rigging Drive Annapolis, Maryland 21401 Helen Hart Needle 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 0 Department of Important: If any injury or once. Metro Crematory Inc. 01/27/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ^{*}Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 × No Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 ADOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 3 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nucse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29h Sinnature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 16

Registrar
DHMH 17 Rev 06-2011

State

JAMES

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

1509 Ritchie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHACONAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 27, 2012 Physician/ 11:40 A Sobhy Aziz Nasr Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 20307 Brook Run Place Germantown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 214-11-8143 89 Director 1 X M 2 □ F June 21, 1922 Egypt Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20877 United States 101 Odendhal Avenue #116 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify. White "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Import/Export Director it. Page 1 and 2 should be filed with trinent of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, th Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unk. Aziz Nasr 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20307 Brook Run Place, Germantown, Maryland Said Kamal/Son-in-Law permit. Page 1 and Department of Heall Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 31, 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery 2012 Silver Spring, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Signature of Funeral Service Licensee Willian M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Congestive Heart Failure Medical resulting in death) Examiner Coronary Artery Disease Sequentially list conditions, if any occupy to in relative cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has performed? Yes 2 X N 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital: 4 Nursing Home 5 Residence 6 K Other (Specify) Dtr.'s Res. 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🔲 No 5 Pending injury 1 X Natural 124 hours after death.
 Euneral Director: At eletely filled in by the full Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and of certif D42222 January 30, 2012

State Registrar

Mubashar Choudry, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

11119 Rockville Pike, Suite 100, Rockville, MD

14 hone Humell Palmer Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 02327 12-00653 UNK JNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death al Examiner Tyrone Purnell Palmer Jr. Month 0305 hrs January 24, 2012 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 100 block South Hilton Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** July 23,198 Foreign MD. Director 26 Months Days Hours 1X M 2 F Yrs Usual Residence of Decedent ij 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show : Maryland Windsor Mill 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nort of Health and Mental Hygiene.

Inst. If item 27 is marked other than "natural", or items 23a or 28s-f sho is other traumatic event, the Medical Exemical. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8116 Salt Lake Drive 21244 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Rece - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industries Carpet Cleaner 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) B Tyrone Purnell Palmer Sr. Dwanda Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Tiffany Palmer/Sister 8116 Salt Lake Drive Windsor MIll, MD.21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: MT.Zion Cemetery | 1-31-2012 | Landsdowne MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Chatman-Harris Funeral 1975 5240 Reisterstöwn Rd. Baltimore, MD. 2121 art I. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and Me dies a. Head Injuries Death Immediate Cause (Finel disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, tolor Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? ✓ Yes 2 No. 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jan 24, 2012 1 Natural Driver in an auto to fixed object collision 0240 hrs within 24 hours after death.

To the Fuueral Director: 1 Yes 2 ✓ No Pending ţţ 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 100 block South Hilton Street, Baltimore, MD determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedlcat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 24, 2012

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Shire tur

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

me and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:10A M ,201 Emmett J. Patrick January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Perryville Cecil 10 Anchor Court 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs Hours **Director** 230-24-7542 1**X** M 2 □ F 02/14/1924 87 Virginia 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Cecil Perryville 10e. Street and Number 10g. Citizen of What Country's Funeral 10 Anchor Court 21903 U.S.A. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 8 Truck Driver Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ William Ross Patrick Lottie Melissa Bausell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Pete H. Felts (Brother) 6730 Oak Lake Dr., San Antonio, TX 78244 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Hill Cemt. 02/02/2012 Havre de Grace, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 Washington St., Havre de Grace, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Sheck only one) Hospital: 1 Yes 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending work? 1 🗌 Yes 2 🗋 No injury Natural 5 Pending Certifica death. Accident Investigation filled in by the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) Hospital hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of person who completed cause of dea (Item 23a) (Type, Print) 5XV

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Richard Clarke Pohl Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Square oseda Baltimo 8. Date of Birth (Month, Day, If Unde 6. Sex 9. Birthplace (State or Foreign **Funeral** 83 Yrs. **Director** 219-28-8255 1 🔀 M 2 🗆 F Balt. Maryland March 16, 1928 Usual Residence of Decedent 28a-f show at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Parkville Maryland Baltimore 1 Yes 2 XXVo 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Examiner must be 23a Funeral 21234 8800 Walther Blvd. Apt. 2408 of America items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ō þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Western than Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Electric Industrial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Marie E. Miller Walter F. Pohl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other training. 8800 Walther Blvd. Apt. 2408 Parkville, Maryland Mrs. Evelyn A. Pohl/ wife Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State January 30 cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air 1 Burial 2XXCremation 3 Removal from State Forest Hill, Maryland 2012 4 Donation 5 Other (Specify) Signature of June Service Licen 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph.sician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending injury Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Dr. Balto, UD 21237 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARSONS Physician/ Month ANYE 11:50 A 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Brooklyn Park Genesis Health Care Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Director 1 M 2 XX 220-74-6614 78 March 30, 1933 PΑ Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director MD Brooklyn Park Anne Arundel 1 Yes 2xx No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21225 613 Hammonds Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Never Worked N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Polly Eve Hetrick Raymond Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 84, 422 Obrecht Rd., Millersville, MD 21108 Doris Polly Nolan Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 remation 3 ☐ Removal from State Jan 26, 2012 Baltimore, MD 4 Donation 5 Other (Specify) Bayview Crematory 21. Signy unit of Fungary Service Livens Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 23a. Part 1 Part 1. Enter the disease, or o shock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ne cause on each line. 6 Immediate Cause (Final disease or condition resulting in death) REPORAT Physician Medical Due to (or as a consequence of): Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occur rred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year

APOLIS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #8.per TNF, 9935 1-8-12 SM
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 27 Year Physician 2012 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Sandtown Homora Car If Under 24 Hrs 8. Date of Birtl4/23/192 (Month, Day, lear) 9. Birthplace (State or Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Yrs. 72 Director 47-42-5712 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be rediffed at 1 4Yes 2 □ No Bullimore Director ma 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 2/2/1 2325 Funeral . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ∐Yes 2 MiNo Specify Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 10 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Laknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anok Careful Altheria 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Trinity 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athers Vo **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical as the attending IF FEMALE: asn yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 0 detached 9 Unknown 9 Unknown signed by to Ф. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 100 certificate has completely filled in by the funeral director, page 2 1 □Yes To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mariner of Death Certification: 5 Pending investigation Injury ✓ □ Natural 1 □Yes 2 □ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier D31865 30. Name and address of person who complet se of death (Item 23a) (Type, Print) Gutar I K. ome m-n-D 20 31. Date filed (Month, Day, Year)

JAN 3 1 201 22: Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Patient known as Koland Ruger
Baltimore Manyand 21215-0036

 $\int \alpha \times \mathcal{M} = \mathcal{M} \mathcal{E}$ Division of Vital Records, P.O. Box 68760

		-	- State Registrar Amend Items 2	tate of Marylar 3aPtI,25,27) 2	02332		
	Physicia Medic			ıger		2. Date of Death John Day Year 05'.00PM							
1	Examir	er	4a. Facility Name (if not institution, give street Sinai 1-05p; Fal & Sy	f Death	<u>′</u>								
	Funeral Director		5. Social Security Number 6. Sex 218-46-9367 Usual Residence of Decedent	7. Age (In yrs.	last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Date of Bir (Month, Da 11/17/	ay, Year)	Countr	ace (State or Foreign y) rland		
	he Maryland or 28a-f show e notified at	Director	10a. State 10b. County MD 10e. Street and Number	10c. Ci			10d. Inside City Limits 1 ☑ Yes 2 ☐ No						
	ith with the ms 23a commust be	Funeral Director	6705 Roberts Avenue	/as Decedent Ever in U. rmed Forces? ☑ Yes 2 ☐ No	.S. 13. V	10f. Zip Code 21222 Vas Decedent of Hi	ispanic Orig	in? (Specify Yes or No- Puerto Rican, etc.)		• ce - America	n Indian,		
-0036	ours after dea stural", or ite	I 👡 I	1 X Never Married 2 Married 1 3 Widowed 4 Divorced Y	1	☐ Yes 2 🗓 No	Specify:	Puerto Hican, etc.)	Specify	Wnlt	e			
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yland	uld be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Harold D. Ruger				18. Mothe	r's Name (First, Middle, a Gib		e)			
e, Mar	and 2 should be Health and Ment tem 27 is marker other traumatic		19a. Informant's Name/Relationship (Type, Pr Randall Ruger / Brot 20a. Method of Disposition	her		olberry C		Paramus, Date	•	2			
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 🛣 Donation 5 ☐ Other (Specify) 21. Signatur 👫 Funeral Service Ucensee)1/23/2012 Anatomy G	Hanove	r, Mar	ryla <u>nd</u>						
B	Dep Imp	j j	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the dea	7!	522 Conne	elley	Dr., Ste.	P, Hano	ver, N			
	Physician Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			irway	065	muchion			Onset and Death G days		
		Examiner	Sequentially list conditions, if any hadring to a cause. Enter Underlying Cause (Disease or injury	Due to (or see a nonsec	nenne off:			92/	OCAL EXAMINER				
09	ite be executed hysician and the burial-transit	g	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):	CENTIFICATION APPROVED BY MEDICAL EXAMINER							
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year								
Division of Vital Records, P.O.	quires that the series of signed by ould be deta	ted by Pł	to the same								acco use contribute to the cause of death? s 2 1 No 3 Probably 4 Unknown		
Recor	: The law recate has be								psy prmed?		sy findings available inpletion of cause of		
of Vital	Physician: r this certifi eral director	To B	25. Was case referred to medical examiner? 1 IX Yes 2 TO No Hospit 27. Manner of Death 28	1 ☑ Inpatient 2 ☐ Ba. Date of injury	ER/Outpatient	Otho	er: 4 🗌 Nur	rsing Home 5 Resident	dence 6 Oth				
rision (r Attending ter death. rector: Afte	Certificate:	7 Natural 5 Pending Investigation 3 Suicide 6 Could not be 4 Homicide 28	(Month, Day, Year) 1/14/2012 e. Place of Injury - At he building etc. (Specif	1:39 p	M 1	? Yes 2 🗶	Subjection 6	t choked	d on b	Route Number		
Ö	Hospital o 24 hours afi Funeral Di stely filled in	Medical C	29a. Certifier 1	n the basis of examination	rledge, death o	ccurred at the time gation, in my opinio	n, death occ	blace, and due to the courred at the time, date a	ore, MD ause(s) and man and place, and du	ner as stated	se(s) and manner stated.		
	To the within To the comple		only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier RIMENTE M		my knowledge,	29c. License			the cause(s) and in 29d. Date signe Janua	d (Month, Da	ay, Year)		
_			30. Name and address of person who comple Rufika Mewia		n 23a) (Type, Pr	rint) eri Hos	spital	of Bai	timore.				
	Stat Registra	e ar	JAN 2 7 2012	2. Registrar's Signa	ture par	Kad							

12-00607 Lavten Reuter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ayten Reuter		State of Maryland / Departmen	it of Health and Mental H e <i>of Death</i>		2012	0233
Physici	an/	Registrar 1. Decedent's Name (First, Middle Last)	o or Bodin	2. Date of Death		3. Time of Death
Medical Exami		Lauten Cosper Keuter		January 22		0910 hrs
		4a. Facility Name (if not institution, give s⊮eet and number) St. Joseph's Hospital	4b. City, Town, or Location of Death Towson	ו	4c. County of Death Baltimore Cour	ntv
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda		s. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	
Director		005-35-5197 1 M 201F	Months Days Hours Mir	Dec. 1	7, 20(1) Foreign	my more MI
		Usual Residence of Decedent		1400.1		
e k		10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f sho d at once,	ctor	MD BALTIMORF WH	10f. Zip Code	100	. Citizen of What Count	
with the Maryland ns 23a or 28a-f sho be notified at once	Director	19128 Graystone Road	21161	"	115A	•
5 72 hours after death with the Maryland 18 "astural", or items 23a or 28a-f sh			B. Was Decedent of Hispanic Origin? (S		14. Race - America	an Indian, Black,
r death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	.1
ural",	Š	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	1 Yes 2 No specify: redent's Usual Occupation (Give kind of	work done I1	Specify: () 1 16b. Kind of Business/In-	17-e
72 hou a "nat	Completed		ing most of working life. DO NOT use ret		/	,
0036 vithin 7, ene. er than Medical	dmo	0	na		na	,
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural" event, the Medical Examine	Be C	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	aiden Surnamé)	
	To B	19a. Informant's Name/Relationship (Type, Print) 19b. M	lailing Address (Street and Number or	Rural Route Numb	er, City or Town, State, 2	Zip Code)
ages I and 2 shount of Health and Nat. If item 27 is not other traumatic		Keith Mandy Kenter-Parents 19	628 Graystone	Rd. WI	nite Hall 1	4D21161
ore, MC ss 1 and 2 s of Health a of Health a Hitem 27			isposition (Name of cemetery, or other place)	Date	20c. Location - City or T	own, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify:	DMC Cemetery JAI	J.27,2012	Gleneve-Sc	arks, MD
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other trauma			22. Name and Address of Facility 169	. /	RD, MONKTO	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en				Approximate Interval
/Medical. Examiner		failure. List only orle cause in each line. Immediate Cause (Final disease a. Sudden Unexplaine)	d Death in Infancy	(SUDI)		Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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3760 ificate ig phys s the b	- 21	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Da	y Year
OX 6876 eath certificate attending phy for use as the b	sicla	past 12 months?	Other (Specify)		l mona, ba	, 154
BO; he deatly the att	Phys	Yes 2 No 9 Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in	the underlying equal sives in Part I	23a Did taba	acco use contribute to the	a cause of death?
i, P.O.	<u>ā</u>	Facts. Outer again contributions contributing to death but not resulting in	the underlying cause given in Fait i.	12 7.2	2 ✓ No 3 Proba	
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Records, The law require ficate has been signated to be a signal of the	<u>d</u>	-		autopsy perform 1 ✓ Yes 2	ed? death?	mpletion of cause of
tal Recian: The certificate ector, page	0	25. Was case referred to medical	26,Place of Death (Check		1 103	2 110
Vita	P	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpa			esidence 6 Other:	
ding P. h. After		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	e of Injury 28c. Injury at Work?	28d. Describe how	w injury occurred	
isior Atteno or death rector: by the	ication	2 Accident Investigation 28e. Place of Injury - At home, farm.	355am	unknown 28f. Location (Stre	eet end Number or Rura	I Route Number, City
Div ppital or ours afte eral Diu filled in	Certific	3 Suicide 6 X Could not be determined (Specify) residence			(e) 19028 Gra	
2 - 2 > 1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of		due to the cause(s	s) and manner as stated	
To the Howithin 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or invessand manner stated.				
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	1	29d. Date signed <i>(Montl</i> January 23, 2012	r, Day, rear)
2	}	30. Name end address of person who completed cause of death (Item 23a)			, ==1====	
		Zabiullah Ali, M.D Assistant Medical Examiner 900 V		MD 21223		
St Regist	ate	31. Date filed (Month, Pary 31) 1 2012 32. Jegistrar's Signature	arke			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2136 Nannie Ross Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Country 115-26-1911 77 **Director** 1 🗆 M 2 🔀 F 12 18 34 NC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location must be notified at Director 1 ¥ Yes 2 □ No MD NA Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3454 Reisterstown Road 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 5 à 1 Never Married 2 Married Yes 2X No Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) other than ementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Brown Morrison Belle McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 Annette Ross Cook-Daughter | 1419 Old Joppa Road, Joppa, Md 21085 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Me<u>morial</u> 2/2/2012 Arbutus, Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-dillure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death CardioVascular Physician/ Atherosclerotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending plant of for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury Natural 5 Pending Accident Investigation М 1 Ves 2 No within 24 hours after death To the Funeral Director: A completely filled in by the 1 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co 29c. License number

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Edna 07:31 AM Mae Rodgers 01 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Agnes MD HOOPAT If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Hours (Month, Day, Year, 73 **Director** 121-30-1774 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director MD Howard Columbia 1 Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral items 23a 8712 Hayshed Lane 21045 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or item ledical Examiner n 11. Marital Status Armed Forces?

1 Yes 2 No b 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Noivorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. 12th grade College (1-4 or 5+) Nurse |Harbor Hospital Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 should be file h and Mental H 7 is marked ot ၉ Issac Hicks Sr. Louise Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Eric Rødgers-Son 705 Fifth Ave, Baltimore, Md 21227 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cedar Hill 2/3/3012 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepain Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): days **Examiner** ailure respiratory Hypoxic Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due umo mão are attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical disease ha <u>nic</u> Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death signed by the aid be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a Was an has yes 2 No To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26432 28 011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rodgen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 26 Month Physician/ 2012 Seymour Rosenberg 10:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home At Rockville Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month 103/1921 New York 109-14-6870 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location notified at Director 1 Yes 2 No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other trauma". items 23a 18700 Walkers Choice Road 20886 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian rmed Forces?

Xyes 2 No Army Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1942-45 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Window Coverings Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Rosenberg Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Filler / Daughter 19001 Stedwick Drive, Montgomery Village, MD 20886 20a. Method of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Chesapeake Crematory 1/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical to (or as a covised) ice of **Examiner** ll elev (Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Dav Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an , page 2 autopsy Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 onty one) Signature and title of certifie Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person

death (Item 23a) (Type,

12-00570 Timothy Bernard		se Type or Print in State of Maryla	and / Departm	ent of	Health	and				gible.	201	2 023		
	Registrar	Circl Middle Lock	Certific	ate of	Death			12	Pate of Dear	eg. No.	201	3. Time of Death		
Physicia Medical Examin			Month January 2	Day	Year	1730 hrs								
<i>(</i>)	Timothy Bernard Ragan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat													
:	1202 Point Re	each			Ocean	Pines			Worcester					
Funeral Director	5. Social Security Nur 230-56-34		68 Months Days Hours Min.							th(MM/D 7/1944	1 Fore	rthplace (State or gn DC puntry)		
b.	Usual Residence of D	Pecedent Db. County	10c. City, Town	or Locati	^n							10d. Inside City Lin		
/land -f show any once	MD	Worcester	Toc. City, Town	TOI LOCALI			cean P	ines	T.	. 0.11	()40-1-0	1 Yes 2 X		
h the Mary 3a or 28a.										U	SA			
r death witi	11. Marital Status 1 Never Married	2 Married Armed F	2 X No	If Y	es, specify	Cuban, I	Mexican, f	n? (Spec Puerto Ri	cify Yes or No can, etc.)		White, etc.	rican Indian, Black, White		
rs after											pecify: nd of Business			
136 hin 72 hou e. than "nati	8	Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 President R								Religious, Non-Profit				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	17. Father's Name (Fi	17. Father's Name (First, Middle, Last) Joseph Ragan Sr. 18.Mother's Name (First, Middle, Maiden S												
MD 212 td 2 should be ulth and Ment m 27 is marl	19a. Informant's Nam	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 6374 Shaundale Drive, Springfield, VA 22152								e, Zip Code)				
	1 Burial 2	a. Method of Disposition Burial 2 Cremation 3 Removal from State Ch Donation 5 Other Specify:							Date /2012	20c. Lo	Beltsv	r Town, State ille, MD		
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21. Signature of Fune Dorota Mars	ral Service Licensee	22. N	ame and A	ddress o	of Facility	Servic	es, PO B	OX 1	413 Baltin	nore, MD 212			
Physician	failure. List only	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Abbreve of cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Death												
xaminer	or condition resulting	Immediate Cause (Final disease or condition resulting in death) a. Attneroscierotic Cardiovascular Disease Due to (or as a consequence of): b.												
	Sequentially list conditions,													
ed nsit	[(Disease or injury tha	il I												
oe execut ician and	UNPENDED	d				-								
sion of Vital Records, P.O. Box 68760, stending Physician: The law requires that the death certificate be executed death. tror: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial - trans	past 12 months?	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									-			
s, P.O. Be nires that the des signed by the si	1 Yes 2 No 3								_					
Sion of Vital Records, P.O. Attending Physician: The law requires that th death. sctor: After this certificate has been signed by your funeral director, page 2 should be detach by the funeral director, page 2 should be detach	Completed						****	_	24a. Was autop perfor	rm <u>ed</u> ?	prior to death?	utopsy findings availacompletion of cause		
tal Rections: The location of the location of	25. Was case referred				26		of Death (C		ly one)					
Vita hysici	0 1 Y Yes 2			utpatient							ce 6 🗸 Othe	er: Scene		
ion of \text{tending Phy} leath.	E 1 Netro	28a. Date (Month	of Injury h, Day,Year) 28b.	Time of I			at Work?		Bd. Describe I	now injur	y occurred			

03 rval and To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by 3 Suicide 6 Could not be Medical Certifi or Town, State) determined 4 Homicide 29a. Certifier (Check only one)

29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 2 Wedlcal Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. January 21, 2012 Hallan 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 2012 ANUARY 3.14AM Rosskopf. Jr. Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIB Anne CIEN BALTIMORE WASHINGTON MEDICAL CENT If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 216-03-7137 Director 1X M 2 □ F 97 11/11/1914 Baltimore, MD 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 28a-f 1 Yes 2X No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a 289 Scotts Glen 21061 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner Armea I ö þ 1 Never Married 2 Married 2 □ No 1942 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 ▼ Widowed 4 □ Divorced "natural" Completed White 1945 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ford Dealership 10 yrs. Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian May Wright John Rosskopf, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lillian Page Wacker/Daughter 289 Scotts Glen Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ☐ Donation 5 ☐ Other (Specify) 01/30/2012 Glen Haven Mem. Park Glen Burnie, MD Signature of F 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave_SW; Glen Burnie, MD 21061 Part 1. Enter the disease, or exploitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ PONC 416 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred : After 5 \square Pending Natural 2 🗌 No Investigation Accident within 24 hours after deat To the Funeral Director: 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d Date signed (Month, Day, Year, 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who

31. Date filed (Month

1 Oc

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month muari STEVEN ROBINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jakul and more N/A 8. Date of Birth (Month, Day, Year) ast birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. **Funeral** Director 1 X M 2 □ F 212-48-0364 Yrs. 63 AUG. 24 1948 MARYLAND Usual Residence of Dece 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 □ No MARYLAND N/ABALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? injury or other traumatic event, the Medical Examiner must be 23a Funeral 3400 LYNCHESTER RD. 21215 U.S.A. or items 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify should be filed within 72 hours attained Mental Hygiene.

is marked other t an "natural", If Yes, Give Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION SELF 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GEORGE ROBINSON NOVELLA SEWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a : If item 27 is 3400 Lynchester Rd., Apt 2, Novella S. Robinson/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 Department of Important: If ii any injury or or cemetery, crematory or other place) 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Donation Other (Specify) ZION CEMETERY 02 - 03 - 12LANSDOWNE, MARYLAND erayse Keeps 21. Signature of 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying ease with Cickhosis The law requires that the death certificate be executed Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 含 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s autopsy performed' death? Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) fo the within 24 hou. *he Funeral Di Medical Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practitioner: To the best of my knowledge 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 01/18/1012 462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 aryland

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

			For State	State of Maryland / D	epartment of Hea Certificate of Dea		71117	0234
			Registrar 1. Decedent's Name (First, Middle, La		Certificate of Det	2. Date of De		3. Time of Death
	Physici /Medic			hearn		Month O	29 2012	2: 10A
	Examin	er	4a Facility Name (If not institution, give		4b. City, Town, or Loca		4c. County of Death	n
5	Funeral		5. Social Security Number 6. 8	Sex, 7. Age (In yrs. last birti		Under 24 Hrs. 8. Date of Bi	rth 9. Birth	hplace (State or Forei
	Director		212 07-1010	M 2□ F 50	rs. Months Days Ho	ours Min. (Month, D	rth ay, Year) 9. Birth Con	MD
s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. A 1s marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examination in the rediffical management.		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limit	
	ctor	MD	BAU	TIMORE			1XX Yes 2□N	
	with the	Dire	10e. Street and Number	ILL TERRACE	10f. Zip Code 2121	Q	10g. Citizen of What Cou	untry?
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		nic Origin? (Specify Yes or Notes)	1	
22	urs after al', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 To No If Yes, Give Year or Dates:	_	pecify:	Specify: BL	
5	72 hou nature	Completed	15. Decedent's E (Specify only highest gra		l Decedent's Usual Occupation (Give kind of work done during		16b. Kind of Business/I	industry
7	within ene. than "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life, DO NOT use retired) BRICK LAYE	-	PRIVAT	TΕ
2	al Hygi other vent, t	Be Co	17. Father's Name (First, Middle, Last			Mother's Name (First, Middle	e, Maiden Surname)	
y	2 should be filed with and Mental Hygiene. Is marked other than aumatic event, I man	To E	TOMMIE SHEA			TOSEPHINE	Ross	
2	d 2 sh th and th sm 7 Is m traum	ij	19a. Informant's Name/Relationship	Type. Print) (PARENTS) 19b. LINE SHEARN 52	Mailing Address (Street and I	Number or Rural Route Numb L TERPACE	A .	
()	es 1 and 2 of Health fitem 27		20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other place)	Date	20c. Location - City or T	
			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	I Removal from State I	MEMORIAL	2/6/12	BAUTO, 1	MD
	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lice		22. Name and Address of	Facility VAUGHN K ROAD. BA		
				plications that caused the death. Do n				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ver cirrho	Sis		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence o	0:	41.		
	D #	ner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	Def Shardes	ary		
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence o	n.			
Ŝ	ficate be executed physician and s the burial-transit			_ d	.,,			
3	ertifical ing phy e as the	Medical	IF FEMALE:					5,-
	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	sician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year
•	at the de by the stached	Physic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	∃ Other (specify)			
2	res tha signed be det	by P	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in		tobacco use contribute to	
2	w requir been s should	eted		3 1 100 11 100 10			Yes 2 No 3 Pr	
2	The law te has age 2 s	Completed					opsy prior to o ormed? death?	topsy findings availab completion of cause o
	ertifica ctor, p	BeC	25. Was case referred to medical examiner?		26.	1 ☐ Yes Place of Death (Check only	2 ANo 1 □Yes one)	2 🗆 No
5	Attending Physician: The Is redath. ector: After this certificate haby the funeral director, page 2	ို	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. Ti		Nursing Home 5 Res	idence 6 Other (Spec	cify)
5	5 0 0 0	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Year) In	jury Work? M 1 ☐ Yes		now injury occurred	
2	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	3 Suicide 6 Could not b 4 Homicide determined		m, street, factory, office		(Street and Number or Ruwn, State)	ıral Route Number,
1	spital ours a neral D		29a. Certifier 1X Certifying Pl	hysician: To the best of my knowledge,	death occurred at the time, d	date and place, and due to the	e cause(s) and manner as	s stated.
	the Hos in 24 h the Fur pletely	Medical		miner: On the basis of examination and and manner stated.				
	Not To t	Σ	29b. Signature and title of certifier	ARM CAR	29c. License nur		29d. Date signed (Month	h, Day, Year)
		-	30 Name and address of person who	completed cause of death (Item 23a) (*	R1738 Type, Print) LOS Ave., bal.		01/20/2	VIA
			Constance A Rose	CRNP 115 8. Me	hose Ave. bal.	Hmare, no à	11212	
	Sta Registra		31. Date filed (Month 2012 2012	32. Registrar's Signature		٠		

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ajit Singh Month Medical 30 105 2012 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center Rosadale Baltimore **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) India 8. Date of Birth 1 🛛 M 2 🗆 F Director N/A Months Days Hours Year 1937 April 8. Usual Residence of Decedent or 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at with the Maryland 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore White Marsh 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5832 Dillon John Court 21162 India 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 X No Black, White, etc. 3 X Widowed 4 Divorced Completed If Yes, Give 1 ☐ Yes 2 X No Specify: Year or Dates. Specify: Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Singh Agriculture Be Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mangat Singh Prem Kaur 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other tra Harpal Singh Badwal, 5832 Dillon John Court White Marsh, MD 21162 20a. Method of Disposition
1 ☐ Burial 2 🐧 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 02/02/12 Baltimore, Maryland 21. Signature of Funeral Service Licence Thomas Gregor CNADO Funeral Home, P.A. 1 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Interval Between Sepsis Onset and Death Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Small Bowel obstruction Completed by Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Hepatic encephalopath y resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 oholic Liver IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Yes 2 g Unknown Month Day 9 Unknown Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗗 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? To Be Yes 2 No 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 28d. Describe how injury occurred 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 130/12 73048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNannoll 9000 FRANKLIN Square DR Balto md Kun Wour State 32. Regis Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. 12-00745 State of Maryland / Department of Health and Mental Hygiene Robert Simmons 2012 02342 1- For Stata Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0642 hrs Modical Examiner January 26, 2012 Robert Dustin Simmons 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs Director 216-76-1863 country) Maryland 1 XM 2 F 47 06/17/1964 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Marvland Harford Aberdeen Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importaot: If item 27 is marked other than "autural", or items 23a or 28s-f sho
injury or other transmitic event, the Medical Esaminer must be potified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 700 Custis Street UnitedStatesOfAmeri¢a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 X Yes 4 Divorced If Yes, Give Yaar 1 Yes 2 X No specify: Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Supermarket 12 Meat Cutter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) å Franklin Basil Simmons Joan Lee Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) Donna L. Simmons (wife) 102 W. Inca Street, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) West Chester 1 Burial 2 Cremation 3 Removal from State RA Ferris & Co. 01/30/12 Donation 5 Other Specify: Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, PA 123 S. Washington St Havre de Grace, MD man 23a. Part I. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximete Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical AMENDED g physician a UNPENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy attending por use as th 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: director of Vital 盎 Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Subject driver on vehicle involved in motor FOUND: 1 Natural Division 5 Pending 1 Yes 2 ✔ No the vehicle accident Jan 26, 2012 0512 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Beards Hill Road and Route 22, Aberdeen, MD determined 24 hours a Fuoeral 1 (Specify) Major Road / Highway 4 ___ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 27, 2012 O.C.M.E. DOME

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

rar's Sig

32. Regi

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G924 2/03/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner altimore matitan st birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Numbe 9. Birthplace (State or Foreign Age (In **Funeral** Months Hours Country) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 XNo Specify. Specify: Black Be Completed 3 Widowed 4 Divorced 15. Decedent's Education 16b. Kind of Business Industry Un wn 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Butcher A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Imoth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | Stokes/mother 19a. Informant's Name/Relationship (Ty Berger Ave. Baltimore 21206 bowendo Saltimore, 20a. Method of Dispositio 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison 2012 Diwings Mills, 4 Donation 5 Other (Specify) 22. Name and Address of Facility March FH-East 1101 E North 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate terval Between riset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner eass Recognition list according Certificate: To Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury ears To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ihidemiG 3 Probably 4 Unknown 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 2 100 1 Inpatient 2 DER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 🗌 Pending work' Natural 2 🗌 No M 1 Yes Investigation 6 Could not be Accident completed filled in by the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat cause of death (Item 23a) (Type, Print) Samoreitan HospiTAL Goog State 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 6:35 P M Harry Charles Smock, Jr January Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Center 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 89 217-18-9061 **Director** 1 X M 2 □ F Maryland July 10, 1922 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f Parkville 1 Yes XXNo Baltimore Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10 pe Funeral 23a 21234 must k United States of America 3503 Linbelle Terrace or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural" or i þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXNo Specify Specify: White 3 Widowed 4 Divorced Completed event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Martin Marietta Elementary/Secondary (0-12) College (1-4 or 5+) Materials, Inc. Engineer 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Gamble Harry Charles Smock, Sr. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3503 Linbelle Terrace, Parkville, Maryland 21234 Edith M. Smock-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🂢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Feb. 2, 2012 Elkridge, Maryland 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service License Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ementi disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury and that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): the attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Pregnant at time of death 1 Yes 2 Unknown detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed. Ves 2 No has page 2 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2× No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOS 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 KNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

person who completed cause of death (Item 23a) (Type, Print)

207128

. Suite 4105, Baltmere,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16:59 Physician/ Kalpna Sandipkumar Shah Jan. 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Harford County Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛣 F India 156-11-6249 47 1964 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Havre de Grace 1 🗆 Yes 2 🔀 No Maryland Harford County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21078 India Funeral 1699 Mohegan Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾No Specify: Specify: Indian 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired)

Self Employed (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hemlataben Mansukhlal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1699 Mohegan Dr., Havre de Grace, Maryland 21078 19a. Informant's Name/Relationship (Type, Print) Sandipkumar Shah (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel 01/29/2012 1 Burial 2X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ans Funeral Chapel & Cremation Services Belair Newport Drive, Forest Hill, Maryland 21050 seem of Jum 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths? Month Day Year 5 Other (specify) signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Stump 2012 Рм January 29 1:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 9. Birthplace (State or Foreign Country) Baltimore Mary Land Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days Hours Feb. 24, Months 56 214-74-2611 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f sho by Funeral Director 1 Yes 2 No Maryland Belcamp Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Sandwort Ct. Apt. 103 21017 U.S.A. 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces? Black, White, etc. 0 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event, the IN or other traumatic event. N/A N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johnson Louis Stand Beulah Mae Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat once. Naomi Kirtz (Sister) 19 Taxi Way, Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Bel Air Manorial Gardens February 01, Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — 1
3 Newport Drive, Forest Hill, Maryland 21050 Testenian (M01543) 23a. Part 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine 898682008W if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? After this certificate has been signed by the atte funeral director, page 2 should be detached for Month Day Pregnant at time of death g 🔲 Unknown 1 ☐ Yes ∠ ∟ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 M No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work?
1 Yes 2 No 5 Pending n 24 hours af er death.

e Funeral Director. Afte 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the beef of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature who completed cause of death (Item 23a) (Type, Print) Upper Chosopenko 500 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15:30 **Smi** 2012 01 Medical 4a. Facility Name (if not institution, give street and number) Medica 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland 1 timore f Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** 08-13-40 220-36-7263 71 MD **Director** 1 🛛 M 2 🗆 F Usual Residence of Decedent 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director ms 23a or 28a-f s must be notified 1X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #605 827 N. Arlington Avenue Apt. 21216 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African 9 à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", or, the Medical Exam 1 Yes 2 No Specify: Specify: American 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. lementary/Secondary (0-12) College (1-4 or 5+) 7th Gradé Salvage Company Self-employed other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Smith Newman Reaver permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19a. Informant's Name/Relationship (Type, Print) Joan Smith-Wife 4601 W. Northern Parkway Apt #418 Balto; 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Woodlawn Cem. 02-02-12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease shock, or heart failure. List or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate only one cause on each line Onset and Death Immediate Cause (Final Physician/ teremi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown this certificate has been signal director, page 2 should be Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Tes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at work? 27. Manyler of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 740579440 01/26/2012 completed cause of death (Item 23a) (Type, Print) St, Baltimore, MD, 21201

MDHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:25P Burtice Savage Jan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore Future Care Sandtown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NC 6. Sex **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 🔀 M 2 🗆 F 05-11-30 Min. 239-40-9423 **Director** 81 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1^X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2768 Kinsey Avenue Funeral USA 21223 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etcAfrican þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced ^{Specify}American Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 9th Grade Mechanic Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2768 Kinsey Avenue Baltimore, MD. 21229 Essie Savage-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 02-01-12 Catonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Servee Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23d. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Lasular d'scas Ph, sician/ thorosclerotic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Divisito for es eleo esaduenes of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year per s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? hours after death, uneral Director: After this certificate 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) <u>|</u> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 031861 n'a 30. Name and address of person v no completed cause of death (Item 23a) (Type, Print) Bast md Rm Kou

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:55 AM Hall Schuh January Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under **Funeral** Hours (Month, Day, Year) Director 020-26-9246 1 🞇 M 2 🗆 F 78 Jan 19, 1934 Washington DC Usual Residence of Decede 10a State 10b. County 10c, City, Town or Location 10d Inside City Limits Director items 23a or 28a-f s ner must be notified 1 Yes 2 No Maryland Harford Baldwin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3106 Brandon Hunt Lane 21013 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ,0 by 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. JAN 34 2013 jD. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed White and Mental rivers...
is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) 12 01 Golf Professional Go1f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wendell Lewis Arleene Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 3106 Brandon Hunt Lane, Baldwin, Maryland 21013 Joan A. Schuh/Wife 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 2/4/2012 Important: If i any injury or o 1 X Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W 23a. Part 1. Enter the disease, or complications that caused t shock, or he art failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Car se (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of Manper of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check crtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print Ymonium

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Anna Evelyn Sanders 01/29 2012 09:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year) 91 213-14-3299 1 🗆 M 2 🗓 F Director 12/25/1920 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 4003 Fleetwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home year Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Hoey Katie Lauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Mitchell P. O. Box 1666 Hickory, NC 28603-1666 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/30/2012 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Miller-Dippel Funeral Home Signature of Furnal Price Licensee 6415 Belair Rd Baltimore, Md 21206 Part 1) Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ompleca disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any ding to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lor as a consequence of attending physician and if for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I Director: After the din by the funeral Certificate: 5 Pending 1 Natural □ Accider
 □ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in To the Hospital 24 hours Funeral etely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

completed 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State

Registrar
DHMH 17 Rev 06-2011

CHARLES

N

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

KUMAY

1 2012

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SUITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SWEDBERG 0635 Physician/ Month HESIER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 492 Brightwood Road Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Numbe 6. Sex **Funeral** Days Min 472-28-3221 Director 1 🖾 M 2 🗆 F 09/29/1919 MN 92 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 492 Brightwood Road 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give WWII Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣No Specify: Specify: 3 🗌 Widowed 4 🗎 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5 +** Elementary/Secondary (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last)
Anton Swedberg 18. Mother's Name (First, Middle, Maiden Surname) Amanda Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
492 Brightwood Road Millersville MD 21108 Wife Merneva L. Swedberg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crem 1/30/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Simplicity Crem & Fun Serv 22. Name and Address of Facility 21. Signature of Funeral Service Licenses homs ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsel and D94th shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie ompleted cause of death (Item 23a) (Type, Print) Name and address of person w a

DHMH 17 Rev 06-2011

State Registrar 32. Registr

12-00649

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enneth Smith	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 20 2 0 2										
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	or Bouth	2. Date of Death Month Da	3. Time of Death							
Medical Examine	Kenneth Bris 4a. Facility Name (if not institution, give street and number)	un Smith 14b. City, Town, or Location of	January 23, 2								
	University Hospital	Baltimore	Baltimore								
Funeral Director	220-72-3851 1⋉м 2□F	rs. last birthday) 53 Yrs. If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth(N Min. 02/23/	Foreign							
fue	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location		10d. Inside City Limits							
	MD Carroll	Finksl	ourg	1 Yes 2 No							
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?							
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	2717 Cedarhurst Road, Apt. 5 11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	USA 14. Race - American Indian, Black, White, etc.							
fre des	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Yes 2 No specify:		Specify: White							
nours aft	45 Decedent's Education (Specify only highest grade complete	d) 16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT u		b, Kind of Business/Industry							
11215-0036 Id be filed within 72 hour fental Hygiene. sarked other than "nature event, the Medical Exau o Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12	Mason		Masonry							
5-00 led wit Hygien other the M	17. Father's Name (First, Middle, Last)	18.Mother's	s Name (First, Middle, Maio	den Surname)							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica TO Be Comple	Myrl Smith, Sr. 19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numl		K. Constantine r, City or Town, State, Zip Code)							
MD 21 tid 2 should tith and Me m 27 is ma aumatic ev	Erica Marie Panjehshani / Daughter	1301 Taney Avenue, Fred	lerick, <u>MD 21702</u>								
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other ti injury or other traumatic event, the Med	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Cremation 3 Removal from State										
Baltimore, permit. Pages I an Department of He Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Chesapeake Crematory 22. Name and Address of Facility	1/27/2012	Beltsville, MD							
Balt permit. Departi Importi injury	Dorota Marshall 1) Land	Maryland Cremation	Services, PO BO	X 1413Baltimore, MD 21203							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
/Medical Examiner	Immediate Cause (Final disease a Nail Gun Injury of Head or condition resulting in death) Due to (or as a consequence of):										
	Sequentially list conditions, b.										
ni e	if any, leading to immediate cause. Enter Underlying Cause (Uisease or injuly that imitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Fxar Exar	events resulting in death) Last Due to (or as a consequence)	ice of):									
(0), e be executed ysician and burial - transit	UNPENDED AMENDED										
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate by reath. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but the funeral of the completed by Physician/Metication: To Be Completed by Physician/Metication:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death 3 Ectopic	pregnancy	23d. Date of delivery Month Day Year							
P.O. I that the med by the detached	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Par		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown							
ords, P.C w requires that is been signed to should be deta			24a. Was an	24b. Were autopsy findings available							
of Vital Records, P.O. g. Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detacl in: To Be Completed by F.			autopsy performe								
tal Reccion: The lectrificate lector, page	25. Was case referred to medical	26.Place of Death (
FVital Physician: ar this certifical director, To Be (examiner? 1 V Yes 2 No 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 3 DOA Other,4 28b. Time of Injury 28c. Injury at Work'		sidence 6 Other:							
ion of V tending Phy eath. for: After tl the funeral	1 Natural 5 Pending Jan 22, 2012	2320 hrs 1	Subject shot s	elf in head with nail gun							
Division o To the Hospital or Attending within 24 hours after death. To the Foneral Director: Aft completely filled in by the func-	2 Accident Investigation 2 Suicide 6 Could not be determined 4 Homicide 4 Homicide 6 Could not be determined 4 Homicide 7 Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 2717 Cedarhurst Road Apt 5, Finksbu										
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by Medical Certific	29a Certifier	wledge, death occurred at the time, date and pla ion and/or investigation, in my opinion, death occ	ce, and due to the cause(s curred at the time, date and	s) and manner as stated. d place, and due to the cause(s)							
F 3 F 3	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) January 25, 2012							
	Mu Graney, 112		1	, and any 20, 2012							
	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
State Registra		gnature									
DHMH 17 Rev 1/2001	OCME	ORIGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

12-00330	Please Type or Print in Black
Michael Richard Smoot	State of Maryland / Der

2012 02353

		1- For State Certificate of Death Reg. No.														
Physicia ledical Examin	n/ er	Decedent's Name (First, Middle 1)	Micha	nel Richar	d Smc	oot				2	Date of Dea Month January 1	Day 19, 2012	⁄ear	3. Time of Death 0838 hrs		
		4a. Facility Name (if not institution 1191 Hammond Lane	- · -	umber)		4	b. City, To Odento		ocation of	f Death		4c. Coun	ty of Deat A <mark>rund</mark> e			
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birt	hday)	If Under	1 Year Days	If Under	24Hrs.	8. Date of Bi	rth (MM/DD/YY	YY) 9. Bi Fore	rthplace (State or		
Director		219-58-7924	1 M 2 F		57	Yrs.	Wioritris	Days	riours	IVIII I.	09/	02/1954	C	Country) Maryland		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	.	10c. C	ity, Town	or Locatio	on						10d. Inside City Limits			
aryland Sa-f show at once.	اق		nne Arundel						avidso	onvile				1 Yes 2 Xio		
e Mary or 28a- fied at	Director	10e. Street and Number 1269 Lavall Drive					10f. Zip (Code	2103	25	1	10g. Citizen of	untry? JSA			
with th		11. Marital Status		cedent Ever in	ı U.S.	13. Was	Deceden	of Hisp	anic Origi	n? (Spe	cify Yes or No		ce - Ame	rican Indian, Black,		
	Funeral		Armed F	2 No			_	_		Puerto R	ican, etc.)		nite, etc.	White		
urs afte	þ A	Widowed 4 Div 15. Decedent's Education (Spec	orced If Yes, Give Yes or Dates: cify only highest gra	ITU) 16a.	Decedent'	s Usual 0		n (Give k			Specif 16b. Kind of				
16 n 72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during mo	st of work	-	oo not u sman	use retire	d)	_H	ealthe	are Services		
5-0036 led within 72 Hygiene. other than '	틹	17. Father's Name (First, Middle,	Last)							Name (I	First, Middle,	Maiden Surnar		are services		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Jack Smoot Beverly Wilson														
MD 2. d 2 should lth and M m 27 is ma	2	19a. Informant's Name/Relations Donna Carter / S	, , , , ,			o. Mailing: 410 Ti		•				mber, City or T	own, Stat	e, Zip Code)		
	ŀ	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fr		b. Place o		ion (Name				Date	20c. Locatio	n - City o	or Town, State		
Page First		4 Donation 5 Other Sp	om State		sapeak	e Cren			1/2	7/2012		Beltsv	rille, MD			
Balti permit. Departrr Imports injury o		21. Signature of Funeral Service Dorota Marshall (License	leade	a 11		me and A			Servic	es PO F	ROX 1413	Raltin	nore MD 21203		
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Apr											Approximate Interval Between Onset and			
/Medical		Immediate Cause (Final disease or condition resulting in death)	a Alcoho			tic(Morpl	ine)Into	xic	ition			Death		
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red msit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequenc	e of):											
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3760, ificate be ex g physician s the burial	€ [,	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pr		Feta	l death	3 [Ectopic	pregnand	ev	23d. Date Month		y Day Year		
Box 68 e death certifi the attending ed for use as	Physician	past 12 months? 1 Yes 2 No 9 Unk	4 Pregr	nant at time of			er (Specif							,		
that the de detached for		Part II. Other significant conditi	9 Onkn		ot resulting	in the un	derlying	ause giv	en in Part	t I.	23e. Did t	obacco use co	ntribute to	the cause of death?		
ires that the signed by	<u>8</u>										1 Ye	s 2 No	3 Pro	bably 4 🗹 Unknown		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been selen in by the funeral director, page 2 should	Completed										24a. Was autop			utopsy findings available completion of cause of		
tal Rec		25. Was case referred to medical					26	Place o	f Death ((Check on	1 ✓ Yes		1 🗸 Y	es 2 No		
Vital hysician this certal director	8	examiner? 1 ✓ Yes 2 No	Alternitely Con	Inpatient 2	ER/Q	utpatient		10				Residence 6	Othe	er; Scene		
ding Pl	ë	27. Manner of Death 1 Natural 5 Pend		, Day Year)	l	Fime of Inj			at Work? s 2 🛣 /	- 1	8d. Describe unknow	how injury occ	urred			
r Atten r Atten ler deat irector n by the		2 Accident Inves	tigation	19-12 e of Injury - A		0838 rm, street	шз		200		8f. Location (Street and Nur	nber or R	ural Route Number, City		
Div e Hospital o 124 hours af F Funeral D etely filled i	Certification:	4 Homicide deter	in	vehi	c1e					or Town, S dento	State) 1191 1,MD.	Ham	mond Lane.			
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		30. Name and address of person Zabiullah Ali, M.D.	who completed cau: Assistant Medic			0 W. Ba	altimore	Street	, Baltin	nore, N	1D 21223					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Florence 2. Date of Death Sykes Physician/ Month /23/2012 8:50am Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 281-22-4590 Hours 12/25/16 1 🗆 M 2 🔀 **Director** 95 GA Yrs Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Directo Waldorf MD Charles 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10475 Danwin Court 20601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, e 9 1 Never Married 2 Married 1 Yes 2XXNo If Yes, Give Year or Dates. Black Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Kitchen Aide Hospital 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Callie 17. Father's Name (First, Middle, Last) ည Vester Hosch 19a. Informant's Name/Relationship (Type, Print)

Irene Harrington / Daughter 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 10475 Danwin Court, Waldorf MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1/30/12 cemetery, crematory or other place)
Green Lawn Cemetery 1 Burial 2 Cremation 3 XX Removal from State Columbus. OH 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one caus An each line. ardiovacular Disease Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna
Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Ectopic pregnancy Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascular 1 Yes 2 No 3 Probably 4 Unknown (enkoy lons 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ac 29d. Date signed (Month, Day, Year) 25 2012 006365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway, Annapolis Maryland Ajet Kurp, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 28, 2012 3:55 P M Delores Riese Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 298-03-8084 **Director** 1 □ M 2 🛛 F 96 Yrs. January 1, 1916 Ohio Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Kensington Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 9830 La Duke Drive 20895 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗶 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marken any injury or other traumatic e once. Lillian Lung Frederich Riese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9830 La Duke Drive, Kensington, Maryland 20895 Douglas R. Smith / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Montgomery Crematorium, Inc. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Januarv 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 MO1619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NOUMONIA Ph, i ian/ disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events executed Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No performed the Hospital or Attending Physician; To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 🗌 Yes 2 🗌 No 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

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DHMH 17 Rev 06-2011

Registrar

Truong Bao, M.D. 10110 Molecular Drive #206, Rockville, Maryland 20850

2005

30, UVIS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Sta Registr	

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Eunoral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical E	Physician: To the b xaminer: On the bas	sis of examination	on and/or inves	tigation, in	my opinio	n, death o	ccurred a	t the time, date a	and place, a	ind due to	the cause	e(s) and manner state	d.
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Yea 28 Gertrude Kohlhaas Sinclair 10:40 A M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10926 Wickshire Way Montgomery North Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** . Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 X F Hours Country 94 Director 333-14-7090 Yrs. September Iowa Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 No North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10926 Wickshire Way 20852 United States "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Frank C. Zender Elizabeth C. Steinbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health t James V. Kohlhaas/Son 6367 Country Club Drive, Easton, Maryland 21601 permit. Page 1 and Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 31 cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Montgomery Crematorium 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland 22. Name and Address of FacilityRobert A. . Signature of Funeral Service License Pumphrey Funeral Home/ c. 7557 Wisconsin Avenue Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 M01498 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ Terminal Cardiac Arrhythmia disease or condition minutes Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate Yes 2 X No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No X Natural 5 Pending iniury Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D00065914 January 30, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) Schiffman, Amy MD 9613 Bellevue Drive, Bethesda, Maryland 20814

DHMH 17 Rev 7/2009

State Registrar

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Division

32. Registrar's Signatu

Division of Vital Records, 24 hours after death Funeral Director: within 2

State Registrar

31. Date filed (Month, Day, DHMH 17 Rev 06-2011

Medical

29a. Certifier

(Check

29b. Signature and title

certifie

RONALD JEFFREYS M.D.

1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7601 OSLER DRIVE TOWSON, MD 21204

H0052365

29d. Date signed (Month, Day, Year)

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month trice Uca AM 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last buthday **Director** 1 🗆 M 2 💢 F 05-10-1912 28a-f show 10a. State the Maryland at 10c. City, Town or Location Director notified 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 9665 Corntasse1 21046 Court United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Schutz Ethe1 Kohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9665 Corntassel Ct., Columbia, MD 21046 <u>Richard Tucci / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Metro Crematory Inc 101/30/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ terioselviolu brown Voraclas disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or): Exami Cause (Disease or injury signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown been dereuka 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed After this certificate 2 🗌 No 1 Yes Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 Yes 2 WNo ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D1966 01-28-2012

State Registrar 30. Name and address of person who completed cause of death

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(weat to)

Felies Huy \$ 508 Glen Bornes.

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ec**ed**ent's Name (First, Middle, Last) 2. Date of Death Physician/ January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, 01/28/ Country) - Virginia 1 M 2 T Months Days Hours Min Director 87 2012 235-34-4345 W Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford MD Churchville 10e. Street and Number 10g. Citizen of What Country? Funeral 3405 Level Road 21028 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 other than "natural", If Yes, Give Year or Dates 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of Albert Zoeffel Pearl Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Carolyn Poist (Daughter) 4405 Webster Lapidum Rd., Havre de Grace, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of any injury or 1🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) 01/30/2012 Havre de Grace, MD Cemetery 21. Signature of Funeral Service Licensee Zellman Funeral Home, P.A. cations that caused the death. Do not enter the mode of dying, such as can lac or respiratory arrest, mar P rt 1. Enter the disease or com-hock, or heart failure. Lis Interval Between Immediate Cause (Final Onset and Death Physician/ COONWU disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical that the death certificate be the as IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months 4 Pregnant at time of death 9 Unknown 1 Yes 2 L 9 Unknown page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No Yes 2 WN 1 Yes Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to 26. Place of Death (Check only one) Hospital 2 No. Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 2 🗆 No Accident 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) M)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANUARU Norman Taylor Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner (EDICAL CENTER 8. Date of Birth (Month, Day, Year) Oct. 9, 1918 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. **Funeral** 218-05-4795 Director 1 XM 2 □ F 93 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Baltimore Parkville 28a-f 1 ☐ Yes 2 🏋 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 9623 Dixon Avenue 21234 United States iral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. "natural", Completed WWII 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Western Electric Pipefitter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Felix Krawczyk Anastazya Sieracka and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 9623 Dixon Avenue, Parkville, MD 21234 Mildred Taylor- Wife 20a. Method of Disposition Department of H Important: If ite, any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highwiew Memorial January Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 30, Gardens . Signature of Funeral Service Licenses 22. Name and Evans 8800 I Name and Address of Facility Vans Funeral 800 Harford Chapel & Rd. Parkvi 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Interval Between STENIOS, Onset and Death Ph. sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed use as the burial-tran Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 8 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in his who. 1 Yes 2 No 1 Yes the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 X No Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending ☐ Accident
☐ Suicide Investigation 6 Could not be 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check isoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Prage 29b. Signature and title of 29d. Date signed (Month, Day, Year) January 5 26,2012 ss of person who completed cause of death (Item 23a) (Type, Print) 10W 50N

DHMH 17 Rev 06-2011

State Registrar Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per verb., g923,01/31/2012dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ EL 20 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mano Ce Himore N If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 88 Months **Director** 1 □ M 2 🖼 Yrs. NO Usual Residence of Decedent or 28a-f show e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked outher than "natural", or items 23a or 28a-f show ury or or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 No ti More 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status 12 Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates 3 Widowed 4 Vivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) iocial erk Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) မ raves raves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. +more 201 E altimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Deremation 3 Removal from State cemetery, crematory or other place) 27/2012 more 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Lice 22. Name and Address of Facility to MI 1600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner equal tially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of) page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 10 Unknown 9 Unknowr signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number -07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 NEI IADA Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 28 a 2012 3. Time of Death Gloria L. Thorpe Physician/ 8:15 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Tyr Days Ma(1030 .7925 Months Hours Min Mary Tand 86 Director 220-14-1607 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits notified **Baltimore** 1 X Yes 2 No Maryland 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral United States 21211 2718 Hampden Ave items ? death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 0 ρ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Heatht and Mental Hygiene. The tit fitem 27 is marked other than "natural", or tury or other traumatic event, the Medical Examin tury or other traumatic event, the Medical Examin 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3√√ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOmemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Leonard James Plowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2720 Hampden Ave, Baltimore, Maryland 21211 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mary Thorpe /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February 1, 2012 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. Baltimore, Maryalnd 21211 3631 Falls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed a found Director. After this neutrinate has how account. Cause (Disease or iinjury that initiated events resulting in death) Last as been signed by the attending physician and 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnan in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy director, page performed' death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Yother (Specify) Howaica Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) ☐ Natural 5 Pending work? Fell out of bed in by the 2 Accident Investigation 2012 01 111 3 ☐ Suicide 4 ☐ Homicide 6 \square Could not be Plac of Mury - At home, farm, street, factory, office building, etc. (Specify) Kerwick hulli outer cou 28f. Location (Street and Number or Rural Route Number City or Town, State) ביילים אונים determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifi 29c. License number ၉ 29d. Date signed (Month, Day, Year) MD D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI 6701 CHARLES ST SUITE RAITTHORE 31. Date filed (Month, Day, Year) State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Albrosia Μ Thompson January 1:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8177 Kramer Court Anne Arundel Co. Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Virginia **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 04/27/1918 1 🗆 M 2 🗶 F Director 218-14-9841 93 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8177 Kramer Court 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes : 2 XNo Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: **Black** Completed 3 🕅 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Assistant 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Minor Bessie Smith 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Carter Jones / Glen Burnie, MD 8177 Kramer Court 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Cedar Hill Cemetery | 01/31/2012 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, MD 21. Sonature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & CremationMO1479 2nd Ave SW; Glen Burnie, MD 21061 Services PA; 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and De Physici n weeks disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform Yes 2 No 2 No 1 Tyes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No dealth Investigation fter death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 7900

Point Ct

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 25 Month Physician/ JAME Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOS PITAL APEAKE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** Director 406-36-6703 1 🛛 M 2 🗆 F August 2,1930 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Kentucky Boyd Ashland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41102 3563 Floyd Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Iron Worker Local 769 Iron Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Osborn Benjamin Tarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Moores Mill Road, Bel Air, Maryland Breck Tarr: Son permit. Page 1 and 2 20a. Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1-29-12 Brick Union Cemetery Lloyd, Kentucky 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licenses 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DI3 EASE Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical $M800\omega05785$ Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 autopsy perform 2 X No 1 🗌 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes ER/Outpatient 3 DOA မ 1 Inpatient 2 🗌 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my anision, death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\bigvee P P$ UPPLY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Trickett January Virginia 2012 1:06 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1820 Norfolk Road Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) July 13,1913 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min 7. Age (In yrs. last birthday **Funeral** 1 □ M 2X F 234-03-3995 98 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1820 Norfolk Road 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'any Injury or other traumatic event, the Magnet. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Jay Brand ပ Hazel Swan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Trickett:Son 1820 Norfolk Road, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Ardent Cremation, Inc. 1-27-12 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 Michael 23a. Part1. Enter the disease, or complic 1/2 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical 2 Medica 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person w

31. Date filed (Month, Day, Year)

JAN 3 1 2012

\$3000 (70)

MOYLAND

cause of death (Item 23a) (Type, Print)

GLENBURNIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, Roger Van Slyke 2012 1:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Kline House Hospice Mount Airy If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Louisiana Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Jan. 23, Days Hours ^{rear)}1929 1**X** M 2 □ F Director 83 064-22-9021 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 ☐ Yes 2 X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a, a may injury or other traumatic event, <u>the Medical Examiner must b</u>b Funeral 1600 Berry Rose Ct. #1C 21701 United States 12. Was Decedent Ever in U.S. Armed Forces?
14 Yes 2 No
If Yes, Give 1051- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. Year or Dates. 1951-53 Specify: White 3 X Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sales/ College (1-4 or 5+) Elementary/Seconday (0-12) Salesman Office Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Van Slyke Ethe1 Andre Cassius James Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24145 Preakness Dr., Damascus, MD Roger H. Van Slyke / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 01/25/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign une of Tuneral sé vice Licer-22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Vod Work . 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) second Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause) Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical tatic Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Kline House မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at 1-Natural injury 5 Pending work? 1 \Box Yes 2 \Box No 2 Accident Investigation within 24 hours after death To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

JAN 3 1 2012

DHMH 17 Rev 7/2009

46 B

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D67442

Thomas Johnson Drive, Frederick MD

29d. Date signed (Month, Day, Year)

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Delores Lee Willis Physician/ Jan. 27^{ay} 2012^{ar} 6:00 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia 9500 Windbeat Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Mar Ch Day 1997, 1951 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-54-1178 Maryland **Director** 60 1 M 2 XF Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia Howard Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? Funeral 21046 9500 Windbeat Way USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc., B.Lack by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Nursing Assistant Private Industry Elementary/Secondary (0-12) College (1-4 or 5+) <u>11th Grade</u> Be 17. Father's Name (First, Middle, Last) Authur Lee Willis 18. Mother's Name (First, Middle, Maiden Surname) Mary Carlos ည 19a. Informant's Name/Relationship (Type, Print)

Juanita Delores Thomas/Dau 2500 Windbeat Way Columbia, Mary Land 21046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MTemeter, cremator, or other class. Feb. 3,2012 Landsdowne, Maryland 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman - Harris Funeral Home 5240 Reisters town Road Baltimore, MD. 21215 21. Signature of Funeral Service Ucensee arris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death mediate Cause (Final Physician/ ALCOHOLIC CIRRHOSIS disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attendion about the continuation. for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISEASE 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 No 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify) DAULITERS HOME Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check

only one 29b. Signature and title of c

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DOBERMAN, MA DANIEUE 32. Regist ar's Signature

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

264395

29d. Date signed (Month, Day, Year)

JANUARY 27, 2012

29c. License number

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	1 - For State Registrar				tificate of Deat			g. No. 2	112	02369
Physicia	nn/	1. Decedent's Name (First, Middle, L	.ast)					2. Date of Death Month	K-100	Year	3. Time of Death
Medic		ROBERT	WHIP					JANLIARY	29	2012	8 40 PM
Examin	ner	4a. Facility Name (if not institution, gi			***	4b. City, Town, or Location of Death BALTIMORE			4c. Count		
Funeral			Sex 7.				nder 24 Hrs.	8. Date of Birth		N/A 9. Birthol	lace (State or Foreign
Director		220-22-2585	1 🔀 M 2 □ F	84		Months Days Hou	urs Min.	June 12,	Î927		ngton DC
ld now	٦	Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Loc	eation				10	Od. Inside City Limits
arytar a-fst	ecto		imore	100. 013	y, 10W11 01 E00	Catonsvil	lle			1"	1 Yes 2 XNo
or 28 e not	١	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Count	
is 23a	Funeral Director	719 Maiden Choic	e Lane			212	228		Unit	ed Sta	ites
death r item iner n		11. Marital Status	12. Was Decede Armed Force	2	5. 13. V	vas Decedent of Hispanio Yes, specify Cuban, Mex	c Origin? (Spec xican, Puerto R	ify Yes or No- ican, etc.)		ce - America ack, White, e	
s after al", o Exam	d b	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyl Yes 2 If Yes, Give Year or Date:	No 19	946 1 947 1	☐ Yes 2 🏻 No Spe	ecify:		Specif		hite
hour hatur	olete	15. Decedent's (Specify only highest of	Education	· 1.	16a. Deced	ent's Usual Occupation and of work done during	most of workin	_ 1	6b. Kind of E	Business Ind	ustry
hin 72 ne. than '	Completed by	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. DO	NOT use retired)	most of working	´	Siant :	Food	
ed wil Hygie other ent, th	Be C	12 17. Father's Name (First, Middle, Last	t)		Truck	Driver	Anther's Name	(First, Middle, Ma			
l be fil fental rked tic ev	2	Pattison Whipps	10)								
should and N is ma auma		19a. Informant's Name/Relationship				g Address (Street and Nu					
and 2: lealth em 27 her tr		Penny Cox / Daug	hter			cossfox Circ	cle, Ca				
nt of h		20a. Method of Disposition 1 D Burial 2 X Cremation 3	☐ Removal from St	ate Ce	emetery, crem	sition (Name of patory or other place)	1			- City or Tov	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Importment of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Special Signature of Funeral Service Lice				natory Inc. Name and Address of F					
permi Depar Impo any ir once.		12 Soulin	do	i. ray i		99 Frederick					
		23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	mplications that cau one cause on each	sed the death line.	n. Do not ente	r the mode of dying, such	h as cardiac or	respiratory arres	t,		Approximate Interval Between
hysician/		Immediate Cause (Final disease or condition	a. Car	dio	Respir	aton Arr	est.				Onset and Death
Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):	2					
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	lence of):	Moumon	va .				3 weeks
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Er	nd sta	190	Parkinson	is DIS	anie .		0 1	20 years
be executed sician and burial-transit	ical E	resulting in death) Last	Due to (or	as a consequ	en c e of):						3
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certifi anding use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnar					23d. D	ate of deliver	ry
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ires that the dea signed by the a id be detached f		9 Unknown Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the ur	derlying cause given in F	Part I.	23e. Did toba	cco use con	tribute to the	e cause of death?
ires the signer of the control of th	Completed by										ably 4 Unknown
w require s been si 2 should b	plete							24a. Was an			sy findings available
The law ate has page 2 :	Som							autopsy perform 1 \(\sum \) Yes 2	ed?/	death?	pletion of cause of
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	/			Death (Check of	only one)			
Phys	: To	1 ☐ Yes 2 ☑ No 27. Manne of Death	1 2 Inp	natient 2 1	ER/Outpatien	Other: 4 [e 5 Residen			
nding ath. r: Afte ie fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati	(Month,	Day, Year)	injury	work? M 1 \(\sum \) Yes		d. Describe now	injury occur	red	
nr Atte fter de irecto	Certificate:	3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determined	d 28e. Place of	Injury - At hor etc. (Specify)		et, factory, office	28	Bf. Location (Stre		per or Rural F	Route Number,
pital o		29a. Certifier 1 Certifying Ph	variations To the best								
To the Hospital or Attending Physician: The law requires that the death certificate within 24 burors after death. within 24 burors after death. completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L Medical Exar	miner: On the basis o	of examination	and/or investi	ocured at the time, date a gation, in my opinion, dea eath occurred at the time,	th occurred at th	ne time, date and	place, and du	ue to the caus	se(s) and manner stated.
Vithir Comp	~	29b. Signature and title of certifier	-1			29c. License numb				ed (Month, D	
•		* K. Stierla	2021			RES 00		J	anua y	29	, 2012 .
\ \		30. Name and address of person who	/		23a) (Type, Pi	rint)	2)),		/ /	5	me 21025,MD
Stat	te	LULASE GARAM.	SKANI 32. Regi		ure	3001, 500	Th Has	over Str	cet,	Kaltima	ne 21225,MD
Registra		AUN O T COIS	Leur	strar's Signatu	garle		10				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Weinberg 2012 10:35 A M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 578-12-3569 **Director** 1 □ M 2 🔀 F 96 Aug. 8,1915 Missouri Usual Residence of Decede 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 XYes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 830 W. 40th Street, Apt. 808 21211 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Food Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Sidney F. Westheimer Grace Rothschild 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is
any injury or other trau 6711 E. Camelback Rd., #44, Scottsdale, AZ 85251 Wendy Weinberg/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 01/31/2012 |Baltimore, Maryland Metro Crematory Inc 4 ☐ Donation 5 ☐ Other (Specify) Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc . Signature of Funeral Service Licensee Alyson K under 299 Frederick Rd., Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Probable Physician/ months MEASITTE CONCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence of: in any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires
 24 hours after death.
 Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🔀 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 5 \square Pending Accident 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TEWSON MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month David Warren Sr. Medical mary 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner saltimore N/A **Funeral** In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 214-56-3932 Hours 1/19/1950 Director 1 XM 2 🗆 F 62 MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1028 St. Dunstans Rd. 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore Citv other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Community College 12th N/A Janitor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important; If item 27 is marked ott any injury or other traumatic even David Holsey Delores Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 David Warren Jr.- Son 10302 Sunnylake Pl. Apt.A Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lorraine Park 1/28/2012 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Lue to or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical for use as signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 WUnknown ompletely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 this certificate has 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: ည 1 Yes 1 🛂 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? 1 🗌 Yes 2 🔲 No Accident Investigation within 24 hours after deatl 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifies 29b. Signatur 29d. Date signed (Month, Day, Year) 89662 01/18/12 Mehrizi Name and address of person who completed cause of death (Item 23a) (Type, Print) menriz1

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cedric K. White 100 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A**Examiner** 4b. City, Town, or Location of Death 2020 Burnwood Rd Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min Hours |219-66-7382 Month, Day, Year 2/9/1957 Director 1 №M 2 🗆 F MD 54 with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified N/A 28a-f MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code items 23a or ner must be n ō 10g. Citizen of What Country? 21239 2020 Burnwood Rd. USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Divorced 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the arry injury or other traumatic event, the ones. Omni Hotel Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Lee Quickley Elma Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elma Quickley-Mother 2020 Burnwood Rd Baltimore, MD 21239 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/30/2012 |Baltimore, MD Greenmount Cemt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee March F/H 1101 E. 22. Name and Address of Facility Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dus to (or as a consequence of). signed by the attending physician and detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.

the Funeral Director: After this certificate has b. autopsy performed 2 🗆 No 2 Z No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and/or investigating in the cause of examinating and or investigating and or inv 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2012 Back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 02373 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 200 2018 1:00 P M Thornton F. Webster Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Franklin Square 05 Baltimore 8. Date of Birth (Month, Day, g. Birthplace (State or Foreign Funeral Year 214-03-2266 1 XM 2 🗆 F Director Sept. 04 1917 MD 94 Yrs. Usual Residence of Decedent 28a-f show 10a State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 X No |Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? Funeral 23a 21236 USA 9106 Santa Rita Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 ¥Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Chief Estimator Maritime Administration is marked other Be 17 Father's Name /First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Alfred F. Webster Margaret Voqel permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley Perrego (daughter) 9106 Santa Rita Road, Nottingham, MD 21236 injury or other Date 01 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Feb. Cedar Hill Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility any in Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only Immediate Cause (Final Onset and Death Ph_si_ian/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director; in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completely filled is Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in a stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one)

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Nebster, Thorn to

State Registrar

29b. Signature and title of certifie

Name and

32. Registrar's Signature

29d. Date signed (Month, Day, Year,

Franklin Square Dr. Balto, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month WAR 1 29 2012 9.30 A M Physician/ James D. Woermbke Medical 4a. Facility Name (if not institution, give street and number, **Examiner** ANNE MEDIZAL CENTER BALTIMOPE MACHINICION 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 056-28-7698 Director 1 XM 2 □ F 76 Feb. 23 1935 Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 Pike Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-9636 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Electrical Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theodore Woermbke Wilma Rockwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau (spouse) Gail L. Woermbke 218 Pike Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Glen Haven Cemeterv Glen Burnie, Maryland 2012 21. Signature of Funeral Service Ligense 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> 23a. Pan 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. de th. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final Physician/ MERKEL CEU CANC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence or n the Hospital or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 27. Man r of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina within 24 hours after death.

To the Funeral Director; Af completely filled in by the fu 2 No 1 Yes Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gartifying Nurse Fractitioners To the Sest of my knowledge certifie ハバ pleted cause of death (Item 23a) (Type, Frint) e and address of person who con Hourne 30 L Hospital 32. Registra 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROUSEVERT LAWRENCE W00 13 5 Month 5:10 Am 2012 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-32-7122 Months 1 **X** M 2 □ F **Director** 74 03/20/1937 VA Usual Residence of Deced 28a-f show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 74 Magothy Beach Road 21122 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Black Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Boat Yard 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Lee Woods Boyd Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertraud M. Woods (spouse) 74 Magothy Beach Road, Pasadena, MD 21122 Date 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan. cemetery, crematory or other place) Metro Crematory Inc. Baltimore, Maryland 2012 21. Signature of Funeral S rvice License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or con plic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Immediate Cause (Final Onset and Death ADENOCARCINOMA OF THE RIGHT LING Ph, sician/ disease or condition resulting in death) TAGE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a nor sequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760^C Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Day Year ed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1, Natural 5 Pending iniury work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

— Certifying Number Promittions: To the count of the cause of the ca 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Throwellan 063632 01/26/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. STO 128 GLON SHEND MY 21061 Kuma4, ms 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Max V	Volf	amend #\$tate be Maryland 4 Departm				teg. No. 20	12 0237	
Physic Medical Exan					2. Date of Dea Month January 2	ath Day Year	3. Time of Death 1830 hrs	
		Facility Name (if not institution, give street and number) 219 East Cherry Hill Road	4	4b. City, Town, or Location of Dea Reisterstown	wn, or Location of Death 4c. County of Death			
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 220–62–4622 1 M 2 F 57	hday) Yrs.	If Under 1 Year If Under 24H Months Days Hours M		rth (MM/DD/YYYY) 9	D. Birthplace (State or oreign County)	
nd how any cc.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Baltimore Rei		rstown			10d. Inside City Limits 1 Yes 2 X No	
the Maryland so or 28a-f show tiffed at once,	Director	10e. Street and Number 219 East Cherry Hill Rd.		10f. Zip Code 21136	1	0g. Citizen of What	Country?	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene, if it marked other than "natural", or items 23a or 28a-f sho latic event, the Medical Examiner must be softled at once.	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. If Yes are not part or Dates:	1	I so Decedent of Hispanic Origin? () ses, specify Cuban, Mexican, Puerl Yes 2 🗓 No specify:	o Rican, etc.)	White, et	White	
21215-0036 Juld be filed within 72 hour Mental Hygiene. marked other than "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo		tired)	Constructions (Constructions)	ction	
Z 2 2 2 2 2	To Be C	Ardell M. Wolf	Mailing	Nell	ie Franc	ces Crytze	0-1	
≥ pd 2		Gina Marie Sturm - daughter 17	603	Address (Street and Number or West Lunnonhaus	Dr. Apt	. 9 Golde	en, Colorado	
Baltimore, permit. Pages la Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State cremato	ry or other	erplace) Crematory Jan.			ster, MD.	
		23a. Part I. Enter the disease, or complications that caused the death. Do not	1116	ame and Address of FacilityEck 05 Reisterstown	Rd. Owi	ngs Mills	, MD. 21117	
Physician Examiner	8 4	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cause (Final disease or condition resulting in death)				est, shock, or heart	Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
cuted and transit		events resulting in death) Last Due to (or as a consequence of): d						
60, execut ate be execut hysician and burial - tra	Medical	IF FEMALE: 23a, 27, per 23a, 27, per 23c. If yes, outcome of pregnancy	me,	g924 2-8-12 sm		22d Date of date		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be execute thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown	=	al death 3 Ectopic pregna er (Specify)	ancy	23d. Date of delive Month	ery Day Year	
ls, P.O. B quires that the de en signed by the fuld be detached f	Ď.	Part II. Other significant conditions contributing to death but not resulting in	in the un	derlying cause given in Part I.	1 Yes	2 No 3 P	to the cause of death? robably 4 Unknown	
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed	25. Was case referred to medical		26 Place of Death (Check	24a. Was an autops perform	y prior t ned? death		
F Vita Physicia or this cer al direct	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		3 DOA Other Nursin	g Home 5 R	Residence 6 🗸 Ott	ner: Scene	
Sion of Attending Pi death. ctor: After y the funera	Certification:	1 X Natural 5 Pending (Month, Day,Year) 2 Accident Investigation	me of Inju	1 Yes 2 No	28d. Describe ho	ow injury occurred		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the t	Certific	3 Suicide 6 Could not be determined (Specify)	n, street,	factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or late)	Rural Route Number, City	
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invited and manner stated.	occurre estigation	n, in my opinion, death occurred a	t the time, date ar	nd place, and due to	the cause(s)	
	2	29b. Signature and title of certifier	1	29c. License number O.C.M.E.		29d. Date signed (A January 25, 20		
ϕ	Ī	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900	W. Ba	Itimore Street, Baltimore,	MD 21223			
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year llians -2012 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spri 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yis. last birthday) **Funeral** 1 □ M 2 🗙 F Days 579-34-6554 Director VA 88 03/07/1923 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10h, County "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Director 1 □XYes 2 □ No DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Van Buren St. NW Funeral 20012 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**7** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Federal Government 12 Clerk 7 is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Crockett Charles Η. Gennie Mitchell . 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r Shirley Mae Williams/Daughter Washington, DC 20012 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 612 Van Buren St. NW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 01/24/2012 | Washington, DC Glenwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall - March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician allerosce our disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to inmedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed HTN the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician ası IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown Month Year 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate 2 No 1□ Yes 2 No 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 🗌 Yes 2 🗌 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

2501 mu

CNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Immordinu

JAN 3 1 2012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Month}}{01}$ Day Physician/ 2012 Year 22 11:00P Hugh Workman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Home Arcola Nursing Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Hours Min. Days 91 Ï920 SC Director 249-12-4732 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director iral", or items 23a or 28a-f s Examiner must be notified 1 XYes 2 No MD Silver Spring Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20905 USA 14551 Pebblestone Dr. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Marino once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coast Line Railroad Seaboard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Conner Elizabeth Ezekiel Workman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14551 Pebblestone Dr. Silver Spring, MD 20905 Shirlene Mattison/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Old Beaverdam Cemetery02/02/2012 Newberry, SC 4 ☐ Donation 5 ☐ Other (Specify) Marshall-March Funeral Home 21. Sign ture of Fureral Service Licenses 22. Name and Address of Facility 4217 9th St. NW Washington, DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Acute Myocardial Infarction disease or condition resulting in death) ninutes Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 1 Yes 2 X No ☐ Yes 2 🗶 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 3 No 4X Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work within 24 hours af er death.

To the Funeral Director: Ai completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 01/24/2012 D09834

Registrar

DHMH 17 Rev 7/2009

State

3720 Farragut Ave. #2 Kensington, MD 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rosenbaum,

Year 3

N.

Barry

31. Date filed (Month.

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 02379 George William Woodrow State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ George William Woodrow **Madical Examiner** 1138 hrs January 20, 2012 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital **Bel Air** Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director 212-94-6438 32 09/19/1979 1 X M 2 F Country MD Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. Count MD Harford Aberdeen 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Paradise Road 21001 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 XNever Married 2 2 X No Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: 至 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George William Woodrow Sr Janet Burchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Peters Mother 406 Paradise Road Aberdeen MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Atlantic Crem 1/26/12 Glen Burnie MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service License ThomasAllenPA 7090 Ridge Rd Hanover 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. een Onset and /Medical Death a Carbon Monoxide Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown icate has been signed by the page 2 should be detached for Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other 1 V Yes 2 No After t 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject exposed to carbon monoxide from FOUND: Natural 1 Yes 2 ✔ No Director: d in by the f Pending Jan 20, 2012 propane tent heater in an enclosed space 0820 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide within 24 hours aft

To the Funeral Di

completely filled in or Town, State) Route 22 @ Post Road , Aberdeen , MD determined (Specify) In Tent in Woods Homicide 29a, Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 21, 2012 30. Name and address of person who completed cause of death (Item 23a) OGME Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

12-00546 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Vivian Ruth Walden State of Maryland / Department of Health and Mental Hygiene 2012 02380 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1730 hrs Medical Examine January 19, 2012 Vivian Ruth Walden c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Franklin Square Hospital Rosedale 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex **Funeral** Foreign Counti**M**aryland Days Hours Director 05/05/1934 212-32-5793 1 M 2 X F 77 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No or 28a-f show Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hydjene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 LISA 7800 Scholar Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 × No Yes White If Yes, Give Year 1 Yes 2 No specify: 3 X Widowed 4 Divorced Specify. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

17 is marked other than "natur matic event, the Medical Exami Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anne White John Mavor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23261 Eagle Ridge, Mission Viejo, CA 92692 Nancy Ruth Tippett / Daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 1/25/2012 Beltsville, MD 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Maryland Cremation Services, PO BOX 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Complications of Endocervical Adenocarcinoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate ause. Etiles Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 23a, 27, per me, g924 2-22-12 sm attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown signed by the at 1 be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed^{*} page 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director, examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Wedical** 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. January 20, 2012

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCAVE

Melissa Brassell, MD

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02381 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2012 :49 P anuar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charles .aPlata Genesis of LaPlata 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 X F Months Hours Dec. 25, Yea Virginia 1929 82 **Director** 226-30-8717 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XX No LaPlata Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20646 6900 Rose Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2 🎇 No Specify: 3 ₩ Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Board of Education College (1-4 or 5+) Elementary/Seconday (0-12) P.G. Government Food Service 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Lawerance Kootz Moreland</u> <u>Dessie Rae Richardson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Lane, LaPlata, Maryland 20646 Evelyn Bowie/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Trinity Mem. Gardens Jan. 16, 2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, Maryland 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ure to Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ≥ 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Records, 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other 1 🗆 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending M ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 02382 State
Registra MEND#70erFH, 1/19/12; BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PERCY ALSTON 0100 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Aug. 14 NC Director 237-54-5681 Usual Residence of Decedent show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Yes 2 No MD Prince Georges Beltsville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20705 4200 Taunton Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?

1X Yes 2 \(\sigma\) No 1951 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 1953 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Dept. of Navy Elementary/Seconday (0-12) College (1-4 or 5+) Years Chemist Federal Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever age 1 and 2 should be fillent of Health and Mental nt: If item 27 is marked or y or other traumatic ever ပ္ John Alston Amanda Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Taunton Drive Beltsville, MD 20705 Audrey M. Alston/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State . Page 1 cemetery, crematory or other place) permit. Page Department of Important: If any injury or Glenview Memorial 1/13/2012 Durham, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. Signature of Funeral Serui 3831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Renal Physician/ Failure disease or condition Days) Medical resulting in death) Examiner months Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Dui to (or as a consequence of, -transit Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: as been signed by the attending 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heteru Disease Coronary 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hupertension Severe Pulmonary Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: The la 24 hours after death. Funeral Director: After this certificate ha et dilled in by the funeral director, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 M No Other: မြ 1 SInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D61067 PHYSICIAN January 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Suite 320 Silver Spring Maryland 20904 12520 Prosperity LAURA KHANDAGLE

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jänüary 15 2012 Olive Ruth Alger 11:57 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Autumn Assisted Living Center Washington County Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 172-24-9035 81 Director 1 M 2 XF Sep. 30,1930 Pennsylvania show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Director Maryland | Washington County Hagerstow 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Cameo Dr. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward Angle Sophie varner Angle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Ann everhart-daughter 323 Chimneystone Ct. Hagerstown, MD 21742 20b. Place of Disposition (Name of St. central Kenstor Episcopal 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 1-20-2012 Boonsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) Church_Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ement Medical Due to (or as a consequence of) Examiner 0 sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X certificate has filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 🗗 Natural 5 Pending Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW-6 Waseem 1126 Opal Ct. Hagerstown, MD 21740 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Geneva S. Sach

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert G924 2/21/12 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle, Last) 2 Date of Death Month 1/9/2012 Physician/ 1755 pm м John Carter Bowie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Prince Georges Hospital Center Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 13K3M 2 - F 8/25/1948 219-56-0029 Director 63 Usual Residence of Decedent show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 KNo Upper Marlboro MD Prince George 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1301 Largo Rd. 20774 USA 12. Was Decedent Ever in U.S.
Armed Forces?

XX Yes 2 □ No Vietnam
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation 4 Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dixie Le Carter John Marbury Bowie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harwood, MD 20776 Victoria Barkley Sister 2912 Gray Beech Ct. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 g permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/12/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each [7] Approximate Interval Between Immediate Cause (Final Onset and Death Pnysiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Bence of To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 1 ∐ Yes 2 L g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performe 1 Yes 2 No Yes 2 X No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 \square Yes 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Marrier of Deat Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date 30. Nan who completed cause of death (Item 23a) (Type, Paint) Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** 201 Louise Rebecca Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La ical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2√ F Director May 24, 1920 Maryland 218-38-8551 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Experiment be redified at 1√2Yes 2□No Director Charles La Plata Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? l Magnolia Drive Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Be Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lucy Stepney Frank Hemsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2047 Blue Anchor Court Waldorf, Maryland 20602 <u>Patricia Dyson/Daughter</u> Baltimore, Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Ghost Cemetery 1-17-2012 Issue, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. lavid Echel M00945 211 St. Mary's Ave. Box 567 La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (of as a consequence of): L2 days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending aboversion and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2-5 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 Mak No Certification: To 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. leral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 069566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, La Plata, MD Michel, MD 5 Garrett 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 0819 AM Physician/ Month D CLAYTON ERVIN BENDER Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOMICO Medical PHINSUMA REGIONAL SALISBULG Year If Under 24 Ars. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) If Under 1 **Funeral** Days 144-18-8350 1 **X** M 2 \square F Director 87 6-25-1924 PENNSYLVANIA Usual Residence of Decedent than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2X No SUSSEX DAGSBORO DELAWARE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 19939 U.S. 31138 DOGWOOD ACRES ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE res, Give 1943-1965 Year or Dates 1943-1965 Specify: Completed 3 Divorced other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. AIR FORCE TECHNICAL SERGEANT 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ PEARL KETCHLEDGE JOHN BENDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 1 and 2 s of Health a item 27 i LIS BENDER/WIFE 31138 DOGWOOD ACRES RD, DAGSBORO, DE. 19939 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State MELSON'S CREMATORY 1-15-2012 FRANKFORD, DELAWARE 4 🗌 Donatio Cher (Specify) 21. Signature MENSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a Part 1. Enter the di Part 1. Enter the disease shock, or heart failure. ediate Cause (Final e, or complications that cause List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions to my leading to in mediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death
Unknown g Unknown P.0. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No eral Director: A filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states 3 Certifying within 2 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) D32212 Jan 2017

DH 10+1 State

Registrar

DHMH 17 Rev 06-2011

E. Carroll St. Salisbury MD. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD.

100

Stephen G. Keim

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State RegistralMEND#20bperFH, 1/13/12; EMW, MoCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day **O** 201°2 1:25 Gerald Brotman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chevy Chase Montgomery #609 8100 Connecticut Avenue 9. Birthplace (State or Foreign Country) Rev1in Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🛣 M 2 🗆 F Days Hours 2-20-1918 Director Berlin 074-12-1969 93 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Palm Beach Florida Del Ray Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7748b Lexington Club Blvd. 33446 United States 12. Was Decedent Ever in U.S. Armed Forces? 1942 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 To If Yes, Give Year or Dates 1 ☐ Yes 2X No White 3 X Widowed 4 □ Divorced Specify: Completed 1967 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)

Lt. Colonel

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

Jamie Arthurs

-M01163

23a. P 🚅 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

22. Name and Address of Facility

Ам

US Army

Danzansky-Goldberg

1170 Rockville Pike, Rockville, Maryland 20852

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year,

January 10, 2012

Arlington, Virginia

Approximate

18. Mother's Name (First, Middle, Maiden Surname)

Date token

Frieda Eckleman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Helsel Dr., Silver Spring, Maryland 20906

Feb. 17,2012

Physician/ Medical Examiner

Box 68760

Division of Vital Records, P.O.

Be

မ

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

1 XBurial 2 Cremation 3 XRemoval from State

David Brotman - Son

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Michaela. Westerman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isaak Brotman

20a. Method of Disposition

Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and မ Medical Certificate: within 24 hours after death

To the Funeral Director; A

completed filled in by the fi

Immediate Cause (Final disease or condition resulting in death) a. Ischemic Cardiomyopathy a. Ischemic Cardiomyopathy									
	Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter the certain of Cause (Disease or iinjury that initiated events.	Due to (or as a consequence of):								
resulting in death) Last	Due to (or as a consequence of): d								
 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 X Yes 2 No 3									
		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s					
25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)							
1 ☐ Yes 2 ☐XNo		ome 5 🕅 Residence	6 Other (Spec	cify)					
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Month, Day, Year) Injury work? M 1 □ Yes 2 □ No	iry occurred							
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ural Route Number,							
(Check 2 Medical Examir	ician: To the best of my knowledge, death occured at the time, date and place, an ner: On the basis of examination and/or investigation, in my opinion, death occurred at e Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place	e, and due to the	cause(s) and manner stated.					

29c. License number

D52451

8901 Rockville Pike, Bethesda, Maryland 20889

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland /	-						012	02388	
			1 - State Registrar			Cer	tificate of	Death			Reg. No.	012	0 2 0 0 0	
	° Physici	an	Decedent's Name (First, Middle, I	0 1 .						2. Date of De Month	Day		3. Time of Death	
ý	/Media		4a. Facility Name (If not institution, g	odsky			4b. City, Town,	or Location	of Death		3	20 /2 County of Death		
	Examin	ier	Bedford Court		ivino		Silver					ontgome		
	Funeral			. Sex 7. Age	e (In yrs. last t	birthday)	If Under 1 Year Months Days			8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign untry)	
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits	
	Maryl f sho	tor	MD Montgo	nme rv	Silve	r Sn	ring						1 X Yes 2 □ No	
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	r dea	Funeral	11. Marital Status	12. Was Decedent 8 Amed Forces?	Ever in U.S.	13. V	Vas Decedent of I	Hispanic Ori an, Mexicar	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.))- 1	14. Race - Amer Black, White		
20	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or Items 23s or 28e-f show event, the Michell Examinational be nufficed at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give	No	1	☐ Yes 2 🖾 No	Specify:				Specify: W	hite	
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and	be file ta! Hy d oth	Be (17. Father's Name (First, Middle, La	st)				18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
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Mar	12 sh h and 7 Is π treum		19a. Informant's Name/Relationship	, , ,			g Address (Stree							
a) (1)	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other treumetic QDCB.		Anita Rand - D	aughter			8 Royal sition (Name of patory or other pla			Lrcle, ate		nersbur cation - City or	MD 20886 Town, State	
baltimor	ages ont of t: If it		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		1			1	1 -	1.0			ch,Virginia	
	nit. Partme orten injur		21 Signature of Funeral Service Lie	censee . I	KING I		Mem. Gar		1-5	-12 nzansky			.cn, vii ginia	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	e of):								
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	₽ ₺	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e oi):						Į		
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Ö	rtificat ng phy as th		IE ESMAN S							<u> </u>				
X O C	w requires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy									23d. Date of delin		
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	ding Physicien: The lav h. After this certificate has funeral director, page 2	Completed				-				auto	psy ormed?	prior to death?	completion of cause of	
N I G	ien: Trifical	0	25. Was case referred to medical	1'5 DISE	acse			26. Place	e of Death	1 Yes		1 105	2L NO	
	nysici direc	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatien	t 3 DOA Ot	her: 4 Nu	ursing Hor	ne 5 ☐ Resi	dence 6	S □Other (Spec	cify)	
5	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b y Year)	. Time of Injury	Wo			28d. Describe	how injury	y occurred		
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5	To the Hospitel or Attending Physicien: The law requires that the death within 24 hours after death. To the Funerel Director: After this certificate has been signed by the atter completely filled in by the tuneral director, page 2 should be detached for the funeral director.	Certification:	4 Homicide determine		ury - At nome, c. (Specify)	farm, stre	et, factory, office		4	City or To			ral Route Number,	
	spitel ours nerel filled		29a. Certifier 1 Certifying	Physician: To the best of	of my knowled	ge, death	occurred at the t	me, date ar	nd place, a	and due to the	cause(s)	and manner as	stated.	
	the Hospitel or nin 24 hours afte the Funerel Dir moletely filled in	Medical	(Check only 2 Medical Ex	caminer: On the basis of	f examination a	and/or inv	estigation, in my	opinion, dea	ath occurre	ed at the time,	date and	place, and due	to the cause(s)	
	To the	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date	e signed (Montl	n, Day, Year)	
			hope	M.D			DO	598	00			1-4-	-12	
			30. Name and address of person wh	to completed cause of de	eath (Item 23a	a) (Type, I	Print)		1	11/2	k.d v)		
			Tao Yu , 1524 31. Date filed (Month, Day, Year)	and manner sta M · D no completed cause of de Shady Registra	ar's Signature	Ko	1, #/3	0, R	COCKI	11110,	rel	1 208	30	
	Sta Registr		1AN 1 2 20	112 / 1	1	par	No.							
			JAN TO CO	116										

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or I								_	ible.	
		For State		State of	Marylar		•		lealth and I	Mental Hy	giene	9		
	_	Registrar 1. Decedent's Name	e (First Middle	l ast)			Certificate	Of L	Jeath	2. Date of De	Reg. No	ه. 20	12	0 2 3 8 9 3. Time of Death
Physicia		Daniel	o (i moi, imaaro	Howard		Ro	achley		Month Januar	D	ay 2	Year 012	7:10 p M	
Medic Examin			not institution,	give street and numb	er)	<u>DC</u>		wn, or	Location of Death			c. County		7.10 P
		5737 Mt.	Carme	1 Church F					onsboro			W		ngton
Funeral Director	Director	5. Social Security No. 214-30-1		6. Sex 1 X M 2 □ F	. Age (In yrs 81	last birthda Yrs	Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 15	v. Year)	930	Count	place (State or Foreign try) Cvland
		Usual Residence of	Decedent							june 1.) <u>, 1</u>	9301	riai	yland
ryland -f sho ied at		10a. State	10b. County		10c. Ci	ty, Town o							11	0d. Inside City Limits 1 Yes 2 X No
he Ma or 28a notif	Dire	Maryland 10e. Street and Nun		hington		Вос	nsboro 10f. Zip C			10a. C	itizen of W	hat Coun		
with t	Funeral	5737 Mt.	Carme	1 Church F	Road			21	1713				.S.A	
items items		11. Marital Status		12. Was Deced	ent Ever in U.	.S.	13. Was Deceden		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		14. Race	- America	an Indian,
after al", or Examil	d by	1 ☐ Never Marri 3 ☐ Widowed		ied Armed Ford 1 🛣 Yes If Yes, Give Year or Dat	195		1 🗆 Yes 2			•		Specify:		ite
hours natura lical E	Completed		15. Deceden	es. 195	16a. De	ecedent's Usual (Occupa	ation		16b Kind of Business Industry				
nin 72 ne. :han "	ошо	Elementary/Seco		st grade completed) College (1-4	or 5+)	life	e. DO NOT use re	etired)	during most of work	king				
Hygier Hygier other ant, th	To Be C	9 17. Father's Name (F	First Middle I	asti			Security	7 Gi	uard 18. Mother's Nam	o (Eirst Middle				acturing
be file lental rked c		George I								E. Mark		Surrame)		
and M is mai		19a. Informant's Na				19b. M	failing Address (S	Street a	and Number or Rur			r Town, St	ate, Zip C	code)
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Frances	L. Bea	chley/Wife					el Church	Road,				
ge 1 and of H			X Cremation	3 Removal from S			isposition (Name crematory or othe		(e)	Date		ocation -		
nit. Pa artmel ortani injury		4 Donation 21. Signature of Fur			S	Stauf:	fer Crem							Maryland Home, P.A.
permi Depar Impo any ir		* LII	ar -	. Un	nne	~								land 21713
		23a. Part 1. Enter the shock, or hear	he disease, or t failure. List o	complications that ca nly one cause on eac	used the deat	th. Do not	enter the mode o	of dying	g, such as cardiac	or respiratory arr	rest,			Approximate Interval Between
Physician/		Immediate Cause (I		a	Pr	seu	mon	19					l	Onset and Death
Medical Examiner		resulting in death)	1	Due to (o	r as a conseq	uence of):	in Cin	- 1	Disca.	P				TUPBA
	ner	Sequentially list con if any, leading to im	mediate	b. Due to (o	r as a conseq	uence of):	/VI > VI)	1	DISCH I			-		s years.
executed ian and irial-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	iinjury	с										
e exec cian a ourial-t		resulting in death) L	_ast	Due to (o	r as a conseq	a consequence of):								
icate be physici s the bu	Physician/Medical			d										
ath certifice attending p I for use as t	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outco	ome of pregna		3 🗆 Ectopic pre	ananc	*V			23d. Date	e of delive	ery
death he atte	sici	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown			ant at time of		5 Other (spec		· y			Mon	ith	Day Year
iires that the dea signed by the a ld be detached f			icant conditio	ns contributing to de	ath but not re	ulting ih /	ie unde lying cau	use giv	en in Part I.	23e. Did to	bacco	use contri	bute to th	e cause of death?
requires the been signer should be	Completed by		9	ns contributing to de ATMV	-)t	m //	aus			1 🗆 '	Yes 2	□ No	3 🗌 Prob	pably 4 Unknown
w requisibles	plet			Atlan	Clan	rel	5			24a. Was				osy findings available
The law cate has page 2 s	Com					37				autop perfo 1 🗌 Yes	rmed?		eath?	
ician: certific ector,	Be	25. Was case referre examiner?	1	Hospital:				26. Pla	ace of Death (Chec					
Phys r this eral dir	e: To	1 Yes 2 2 27. Manner of Death	No	1 ∐ Ir 28a. Date of	injury	28b. Tim		. Injury	4 L Nursing H	ome 5 Resid				
ending tath. rr: Afte	icat	1 Natural 2 Accident	5 Pending	ation	, Day, Year)	inju	ry M	work'			,	,		
or Atter fter de irecto irecto n by tł	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could r determi	ned 28e. Place o	f Injury - At ho , etc. (Specif)		street, factory, o	office		28f. Location (S City or Tow			r or Rural	Route Number,
pital o		29a. Certifier 1	Cortifuing	Physician: To the bes	at of my know	ilodgo des	ath occured at the	o timo	date and place as	ad due to the ca	ueo(e) a	nd manne	r ac ctato	4
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death can within 24 hours after death of the this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director is a second to the detached for the funeral director.	Medical	(Check 2	Medical Ex	xaminer: On the basis Nurse Practioner: To	of examinatio	n and/or in	vestigation, in my	opinio	on, death occurred a	it the time, date a	nd place	e, and due	to the cau	ise(s) and manner stated.
To the within To the Complex c		29b. Signature and t	itle of certifier	41			29c. Li	icense	number		29d. Da	ate signed	(Month, E	Day, Year)
			TIP			:	12	44	1996		Je	11140	ny	17, 26/2
N-la		30. Name and addre	espot person v	completed cause	of death (Item	n 23a) (Typ	(A)	20	311 Cay	ppams	R	of Be	onshi	16, 2012
Stat		31. Date filed (Monti	ANY	2012 32.	jistrar's Signa	ature	1			-				4113
Registra	ar			14	me	A. 1	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 850 M JAMES HOWARD BURKS January 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UNION MEMORIAL BALTIMORE 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director 223-34-7350 1 M 2 🗆 F 81 Yrs MARCH 5, 1930 VIRGINIA show 10b. County at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f 1 🗆 Yes 2 😾 No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 2521 OLD ROBINHOOD ROAD 21078 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces' Black, White, etc. Yes 2 No þ 1 Never Married 2 X Married ö and 2 should be filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: UNK BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DISABILITY SPECIALIST SOCIAL SECURITY marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I ည UNKNOWN IRENE BURKS and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a CATHERINE BURKS / WIFE P.O. BOX 1093, HAVRE DE GRACE, MARYLAND 21078 Department of Healt Important: If item 2 any injury or other 1 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) BERKLEY CEMETERY 1/21/12 DARLINGTON, MARYLAND 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, 552 LEWIS STREET, HAVRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Acute renal failure disease or condition Medical resulting in death) **Examiner** tract Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Year Day Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 12,2012 AT2438946 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway, Baltimore Dr. Undy Watanaskul 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and	Mental Hygiene	0 00001				
		_		rtificate of Death	Reg. No. 20	2 02391				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of DeathMonth Day Ye	3. Time of Death				
	Medic	al	John Donald Bauma		January 16, 20	15 8.54 AW				
	Examin	er	4a. Facility Name (if not institution, give street and number) Howard County Guencral Hosp. Fal	4b. City, Town, or Location of Deat		sard				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs		. Birthplace (State or Foreign				
	Director		133-50-5288 18M 2 5	Months Days Hours Min.	(Month, Day, Year)	Country) New York				
	- M		Usual Residence of Decedent		03/30/1901					
	ryland -f sh	ctol	, , , , , , , , , , , , , , , , , , , ,			10d. Inside City Limits				
	r 28a notif	Dire	MD Howard Elkrid	10f. Zip Code	10g, Citizen of Wha	1 Yes 2 No				
	vith th	ral	6055 Avalon Drive	21075	United S	,				
	eath v	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race -	American Indian,				
9	fter de , or it amine	by	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	Diacity	White, etc.				
21215-0036	72 hours after death with the Maryland n'matural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		Specify: T	White				
1 5-	72 ho n "na ledica	nple	(Specify only highest grade completed) (Give	edent's Usual Occupation Hiskind of work done during most of wo. DO NOT use retired)	orking 16b. Kind of Busin	ess/Industry				
12	within giene. ier thai	Con	Elementary/Secondary (U-12) College (1-4 or 5+)	ntractor	Electr:	ical				
b	요수들	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maiden Surname)					
ylar	should be fil and Mental is marked or aumatic eve	To	Joseph Bauman	Erna	Paetow					
Baltimore, Maryland	1 and 2 should be if Health and Men item 27 is marke other traumatic	.89	19a. Informant's Name/Relationship (Type, Print) 19b. Mail Dana M. Bauman/wife 6055	ing Address (Street and Number or Ru Avalon Drive El	ural Route Number, City or Town, State Lkridge, Maryland	e, Zip Code) 21075				
e)	1 and 2 s of Health item 27 other tra									
סר			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	osition (Name of matory or other place) on Mem Gardens 1/2	Date 20c. Location - Cit	sville, MD				
ij	permit. Page Department of Important: If any injury or once.		11 21	ii						
Ва	permit. Departr Importa		Juanita Rehomos	112 Old Columbia	rry H. Witzke's F. Pike Ellicott Ci	Ey, MD 21043 nc				
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx										
	h, sician/		Immediate Cause (Final			Interval Between Onset and Death				
	Medical Examiner		resulting in death) Due to (or as a consequence 1):							
		į.	Sequentially list conditions, b. Lung Car	rcer		4 months				
	ed Isit	mine	if any, leading to immediate Due to (or as a consequence oi): cause. Enter Underlying Cause (Disease or injury							
	ecute and	Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence of):							
0	certificate be executed inding physician and use as the burial-transit	dical Examiner								
3760										
(687	endin r use	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy	23d. Date o	23d. Date of delivery				
Вох	death he atte	Physician/Me		Other (specify)	Month	Day Year				
P.O.	that the ned by the e detach	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribu	to to the eques of death?				
ر. ح	requires that the death certifics been signed by the attending p should be detached for use as i	d by	The state of the s	and the second s		Probably 4 Unknown				
ğ	requii been should	lete				e autopsy findings available				
မင္မ	The law ate has page 2:	Completed			autopsy prio performed? dear	r to completion of cause of th?				
<u>د</u> ۳	sician: The certificate rector, pag		25. Was case referred to medical	26. Place of Death (Che	1 - 100 11	Yes 2 No				
Vita	ysicia s cert direct	To Be	examiper? 1 ✓ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ €R/Outpatie	Other:	Home 5 ☐ Residence 6 ☐ Other (S	Specify)				
of	ng Phy ter thi neral		27. Manner of Death 28a. Date of injury 28b. Time of		28d. Describe how injury occurred					
on	tendir eath. or; Af the fu	ifica	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 🗌 Yes 2 🗍 No	= = = = =					
Division of Vital Records,	l or Att after d Direct I in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number o City or Town, State)	r Rural Route Number,				
۵	To the Hospital or Attending Physician: The law requires within 24 hours after death. Of the Funeral Director After this certificate has been sign completely filled in by the funeral director, page 2 should be		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause(s) and manner	as stated				
	e Hog n 24 h e Fun sletely	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or inventor only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred	at the time, date and place, and due to	the cause(s) and manner stated.				
	To the I within 2 To the I comple	2	29b. Signature and the of certifier	29c. License number	29d. Date signed (N	Ionth, Day, Year)				
			I Hote Kyill, and	D41699	H. II, mo	1 16,2012				
		-	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Edna R.	H. II, MO.					
1	0			,5755 (edar L	ane, Columbia	1 MD 21044				
	Stat Registra		31. Date filed (Month Day, Year) 8 2012. 32. Registrar's Signature 9.	arked						

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla	-	artment of F tificate of D			2012	02393	
			Registrar 1. Decedent's Name (First, Middle, Last)			uncate of L	ocatii	2. Date of Death		3. Time of Death	
	Physicia Medio		Kathryn J. Basset					Month 01	17 2012	1:36p.M	
	Examin	er	4a. Facility Name (if not institution, give st	reet and number)			Location of Death		4c. County of Death		
	·		Carroll Hospital 5. Social Security Number 16, Sex	7 (17	I - A I SAI - I - A		inister If Under 24 Hrs.	8. Date of Birth	Carrol1		
	Funeral Director			M 2 x F 69	. last birthday) Yrs.	Months Days	Hours Min.	10-04-1	942 Penn	hplace (State or Foreign untry) Isylvania	
	d t ow	L	Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	nation		· -		10d. Inside City Limits	
	urylan a-f sh ïed a	ct			,					1 🗆 Yes 2 😾 No	
	or 288	اقّا	MD Frederic 10e, Street and Number	K N	lount Ai	10f. Zip Code		10	Og. Citizen of What Co		
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	4910 Buffallo Roa	d		217	71		USA		
	r item iner n		THE THE PARTY OF T	Was Decedent Ever in t Armed Forces?	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
Maryland 21215-0036	s after ral", o Exam	Completed by	1 ☐ Never Married 2 ★★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2🙀 No	Specify:		Specify: whi	Specify: White	
2-0	"natu dical	plet	15. Decedent's Edu (Specify only highest grade		16a, Deced	dent's Usual Occupa	ation	ding.	16b. Kind of Business I	Industry	
2	hin 72 ne. than '	E	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Di	O NOT use retired)	Ü	us ig			
2	d wit tygiei ther i	Be C	12 17. Father's Name (First, Middle, Last)		sel	f employ.			Crafts	<u> </u>	
and	be file ental H ked o c eve	To E	Howard L. Titus					ne (First, Middle, Ma $1. $	aiden Surname)		
<u>3</u>	ould Me mar mar		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street a			City or Town, State, Zip	Code)	
ž,	nd 2 sh saith a n 27 is er trai		Ronald D. Bassett					int Airy,		1	
Baltimore,	je 1 an t of He Miter or othe		20a. Method of Disposition 1	emoval from State		natory or other plac			20c. Location - City or	1	
<u>Hi</u>	t. Pa tmer tant ijury		4 ☐ Donation 5 ☐ Other (Specify)	1		ve Cemet		-24-2017	Mount Air		
Ba	permir Depar Impor any ir once.		21. Son In of Funda Service Lic hisse	M013					eisel Fune hambersbur	ral Home g, PA, 17202	
П			23a. Part 1. Enter the disease, or complic	cations that caused the de			~			Approximate	
Į	Pnysician/	8 77	shock, or heart failure. List only one Immediate Cause (Final disease or condition	MYOCARP	1 A J . I	NEADO	TION			Interval Between Onset and Death	
Medical resulting in death) Due to (or as a consequence of):											
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	nted d ansit	amin	cause. Enter Underlying Cause (Disease or iinjury		equerice oi).						
	ate be executed ohysician and the burial-transit	dical Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):						
90	ate be	dice	d								
687	eath certifice attending p I for use as t	/Me	IF FEMALE: 23b, Was decedent pregnant	3c. If yes, outcome of preg	nancy				22d Date of doll	23d. Date of delivery	
Box 687	atten atten I for u	iciar	in the past 12 months?	1 Live Birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnanc Other (specify)	ey .		Month	Day Year	
Э.	the de by the ached	Physician/Me	9 Unknown	9 Unknown							
, P.O.	requires that the der been signed by the s should be detached		Part II. Other significant conditions con		esulting in the u	nderlying cause giv	en in Part I.		Did tobacco use contribute to the cause of death?		
rds	equire	eted	ASTANIA C	BESITY						robably 4 Unknown	
Division of Vital Records,	sician: The law is certificate has k lirector, page 2 s	Completed by						24a. Was an autopsy perform	prior to oned? death?	topsy findings available completion of cause of	
<u>=</u>	in: Th ificate or, pa		25. Was case referred to medical			26 Pla	ace of Death (Chec	1 Yes 2	No 1 ☐ Yes	2 No	
Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No	ospital:	FR/Outpatier	Othe	er'		nce 6 Other (Speci	ify)	
of	ng Phys fter this ineral dii		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		/ at	28d. Describe hov			
ion	tendi death. tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 ☐ No				
ivis	I or Attending after death. Director: After I in by the funer		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my knoer: On the basis of examinat	owledge, death o	occured at the time	, date and place, a	nd due to the cause	e(s) and manner as sta	ited.	
	To the H within 24 To the F complete	Me	only one) 3 Certifying Nurse	Practioner: To the best of	my knowledge, o	death occurred at the	e time, date and pla	ce, and due to the c	cause(s) and manner as	stated.	
	F. ≚ 5 8		29b. Signature and title of ceft lier	my -			0620	00 -	ANUARY	17.2012	
			30. Name and address of person who cor	mpleted cause of death (Ite	əm 23a) (Type, F				/	1 6	
	OV		George John-7	PYTROS							
	Stat Registra		31. Date filed (Month JAN 3) 1 201	2 32 Registrar's Sign	A. A.	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 14, 2012 2012 0937 ANNIE ELIZABETH COLBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES FORT WASHINGTON 12320 LIVINGSTON ROAD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Director 1 🗆 M 2 🕱 F 217-44-6070 MARYLAND NOV. 9, 1913 98 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGES MD FORT WASHINGTON 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20744 12320 LIVINGSTON ROAD 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOUSE WIFE PRIVATE 8 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ ALVERTA WEEMS TOLSON PERCY TOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 5060 HAWTHORNE ROAD, LAPLATA, MARYLAND AGNES WASHINGTON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State GRACE UNITED CHURCH CEM. 101/21/2012 FORT WASHINGTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

LYDIA C. THORNION JOHNSON M0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 No 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1→☐ Natural 2 ☐ Accident injury 5 Pending s after death.

I Director: After in by the fur 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number filled in by determined building, etc. (Specify) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 045365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livingsfor Ad Hool for WARLyfor MD 20745 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13^{ay} 2012 January 9:23 AM Joseph Meredith Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 10 First St. Lothian If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 215 38 3700 **Director** 1**XX** M 2 □ F West Virginia 71 October 9, 1940 Usual Residence of Deced 28a-f show iral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20711 U.S.A 10 First St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates 1959–1961 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: "natural", 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72., h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Window Glazer P.G. County Schools other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is market any injury or other traumatic e once. Shirley Cooper Margaret Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cooper (Son) 5875 Broomes Island Rd. Port Republic, MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 1/16/2012 Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign re of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc. MO1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 14 (vino acpuded disease or condition resulting in death) 04ea Medical Due to (or as a consequence of) Examiner yeure croudly anvery deglass Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of 1eas Hospital or Attending Physician: The law requires that the death certificate be executed avdio Vescuca and -tran that initiated events resulting in death) Last burialattending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a **To the Funeral D**completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0042049 2012 Mein 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Marlbors.

Registrar

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32 Registrar's Signatur

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2 shouth and in and in a real in traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3112 Beckenham Ct., Silver Spring, Mary										
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Stat		31. Date Med (Mont		32. Regis	strar's Signa	ture La	2	· • • • • • • • • • • • • • • • • • • •	1011	, , , ,	<u></u>	
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			State Registra AMEND#20bperFH, 1/13/12; BWW, McCo Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 201	
г	Physicia		Juana Leon VDA De	Chombo	2. Date of Death Month January 8, 2012	3. Time of Death 5:00 p.M
obere .	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
march .			6121 Wayside Drive	Rockville	Montgom	nery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1	Months Days Hours Min.	(Month, Day, Year)	irthplace (State or Foreign ountry) Pru
	aryland a-f show ified at	Director	10a. State 10b. County 10c. City, Town or MD Montgomery Rockvil			10d. Inside City Limits 1 ☐ Yes 2 No
	vith the M 23a or 28 st be not	eral Dir	10e. Street and Number 6121 Wayside Drive	10f. Zip Code 20852	10g. Citizen of What C	Country?
36	e filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, Wh	
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Baltir	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once.	10	21. Signature of Funeral State Licensee M00982	22. Name and Address of FacilityRap 933 Gist Ave. Silv	p Funeral & Cremat	ion Service
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Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	_ Other:	ome $5 \overline{\! {f X}}$ Residence $6 \Box$ Other (Spe	ecify)
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Division of Vital Records,	28f. Location (Street and Number or R City or Town, State)	ural Route Number,				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or inv	vestigation, in my opinion, death occurred a	t the time, date and place, and due to the	cause(s) and manner stated.
	with a signature of the		29b. Signature and title of certifier WM, 7.D.	29c. License number D30927	29d. Date signed (Mon January 9,	
			30. Name and address of person who completed cause of death (Item 23a) (Type Oki Kwon, M.D. 10313 Georgia Ave.	e, Print) Silver Spring, MD.	20902	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10^{Day} 2012 Harold Gordon Corwin 5:10 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery Hebrew Home of Greater Washington Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Sex 1X M 2 D F 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 12-3-1909 Days Hours Min **Director** 102 128-03-2430 New York Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Chevy Chase MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 3302 Rolling Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. White 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Real Estate Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anna Gordon Morris Cohen Corwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Rolling Road, Chevy Chase, Maryland 20815 Eileen B. Mason - Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Mount Ararat Cemetery 1-13-2012 Farmingdale, New York 21. Signature of Funeral Service Licensee Jamie Arthurs 22. Name and Address of Facility Edward-Sagel Funeral Direction #M01163 1091 Rockville Pike, Rockville, Maryland 20852 23a. Fact : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition neumonia Medical resulting in death) Examiner Failuse Sequentially list conditions. if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death be detached signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed Yes 2 certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 10 Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 🗌 No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760 Completed filled in by the funeral director, 24 hours after deat Funeral Director: within 2

> State Registrar

29a. Certifier

(Check

only one)

A. Chilakamaro

31. Date filed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6121 Montrose

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Chilakamarri, MD

Atchutha

MD

20852

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Blevins Genevieve Campbell 2012 January M 2130 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Health Care Center Rising Sun Cecil If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F 215-18-3631 (Month, Day, 29 North Carolina Director 90 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 U.S.A. 1584 Hopewell Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Midowed 4 ☐ Divorced Specify: "natural" Completed White Year or Dates and Mental Hygiene. s marked other than "natura umatic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Eight Years College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rush Blevins Dorsey Jones and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Campbell (son) Health a 21904 1584 Hopewell Road, Port Deposit, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Port Deposit, 01/20/12 4 Donation 5 Other (Specify) Asbury Cemetery Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) **To the Funeral Director;** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 2No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **X**) No Other: ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work's 1 Yes 2 No Investigation Could not be Accident Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 😰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one)

30. Name and add

31. Date filed (Month, Day, Year)

3 [29b. Signature and the of certifier

serges

s of person who complete

cause of death (Item 23a) (Type, Print

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1156AM DONALD LEMOY Medical TAN 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death HCGH HOWAR Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country) **Director** 212-32-0867 1**X** M 2 □ F 10/29/1932 MD 79 Usual Residence of Dece show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6570 Beechwood Drive 21046 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever In U.S. Armed Forces? 1∑ Yes 2 □ No 1952-If Yes, Give Year or Dates. 1957 Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. I other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineering <u> Electronic Engineer/Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 127 is marked of ir traumatic ever ၉ Preston LeRoy Calp Ethel Leona Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Vonnie Calp - Wife 6570 Beechwood Drive Columbia, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Coremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2012 Ardent Crematory Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signa up of Funeral Service Licensee thomas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HCUTE Pulmonary Homonah 35 Due to (or as a consequence of): Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** NG Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, the burial-trar Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ULCEMATIVE COLITIS Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? MIXED CONNECTIVE TISSUE 24a. Was an autonsy HYPERTINSION 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\sum \) No Hospital: Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred XNatural iniurv work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 06-2011

State

Howard Co. Gan. Hosp, Colyus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Franklin Cage Ronald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Social Security Number 8. Date of Birth Funeral (Month, Day, Year) 1931 Director 216-22-5761 1 X M 2 - F 80 Usual Residence of Decedent 28a-f show 10a, State 10h County items 23a or 28a-f shover her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 812 White Avenue 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 7 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laboratory Technician ABl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment Important: If item 27 is marken any injury or at-Fannie Louise Rinker Albert Franklin Cage other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22611 Berryville Ronna Decker daughter 401 Dunlap Drive VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/27/2012 Sunset Memorial Park MD Donation 5 Other (Specify) Cumberland 22. Name and Address of Facility
Scarpelli Funeral Home, PA ignatu 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events age Injarct Exami resulting in death) Last physician Physician/Medical requires that the death certificate be Box 68760 attending properties of the second IE EEMALE. 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar Manoha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0067876

igalla M.D. 12501 Willaubrook Rd. Cumberland, MD21502

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Francis Xavier Duggan -38A JANUARY 142012 Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-42-5220 **Director** 03/21/1944 MD 10c. City, Town or Location Glen Burnie 10d. Inside City Limits event, the Medical Examiner must be notified at Director Anne Arundel MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 21060 10g. Citizen of What Country? Funeral 962 Point Pleasant Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Boiler Making Elementary/Secondary (0-12) Boilermaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosamond Erline ပ Joseph Duggan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 962 Point Pleasand RD. Glen Burnie, MD 210 60 Patricia Duggan/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Medery Crematory or other place) 01/21/201 Cumberland, 4 XDonation 5 Other (Specify) 21. Signature of Funeral Service Licenses Gerald Potomac Home- 305 N. M01613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) WE THETATIC Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 Pregnant 9 Unknown 1 Yes 2 L 9 Unknown ျှ

Ph_sician/ Medical **Examiner** attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

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and Mental Hygiene.

permit. Page 1 and 2 st Department of Health a Important: If item 27 is

injury or other

as the burial-tran use jo detached signed by director, page 2 should be has filled in by the funeral Certificate: 24 hours after death Funeral Director: Medical

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,	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		se contribute to the cause of death?		
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
	25. Was case referred to medical			ck only one)	inly one)			
	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	Iome 5 Residence 6	ne 5 Residence 6 Other (Specify)			
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	28d. Describe how injury occurred		
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
	29a. Certifier 1 Certifying Phys	sician: To the best of my know	ledge, death occurred	at the time, date and place,	and due to the cause(s) ar	nd manner as stated.		

29b. Signature and title of certifie

(Check

only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 14. 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 00

Glen Burne

20161

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ January 2012 Nell Marie Errico 16:38 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 232-44-0412 Director 1 □ M 2 🗓 F 91 June 24, 1920 West Virginia Usual Residence of Decedent 23a or 28a-f show ast be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Maryland Prince Georges Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 12815 Cheval Ct. 20772 U.S.A items ? 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc Black, White, etc. by 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. If Yes, Give Year or Dates Specify White 3 X Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) of ith and Mental Hygien 27 is marked other the traumatic event, the Apartment Housing Resident Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Caswell Gilbert Maude Ellen Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is or other tra permit. Page 1 and 2 s Department of Health Teddy Celani (Daughter) 12815 Cheval Ct. Upper Marlboro, MD 20772 20a. Method of Disposition

1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of January 20c. Location - City or Town, State cemetery, crematory or other place) ò Important: I any injury o Prosperity, W Blue Ridge Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Sign Jure of Funeral Service Licerse 22. Name and Address of Facility MO1555 Lee Funeral Home, Inc. any in 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final °hysi∟ian disease or condition resulting in death) Medical Due to (or as a co-sequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Director: After this certificate Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Nanpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHAWAJA-A-AROOD Medica

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

JAN 18 2012

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BARA 0825 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min. 578-44-5234 **Director** 1 🗆 M 2 💆 F Yrs. 78 09/11/1933 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Director notified 1 Yes 2 X No MD QUEEN ANNE'S CHESTER 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral UNITED STATES 1830 SHERMAN DRIVE 21619 items Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ☐ Yes 2 X No ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: "natural", Specify: 3 🕅 Widowed 4 🗌 Divorced WHITE Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N SECRETARY RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ JOSEPH MCGARRY ANNA COATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL G. ELLER / SON 1109 HYMAN COURT, CROFTON, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State 101/11/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
LLLOWS, HELFENBEIN & NEWNAM FUNERAL
16 SHAMROCK ROAD, CHESTER, MD 21619 HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ GANGRENE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ORTO-FEMORAL VASC DISEAS OCCLUSIVE YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ab DER FURATED MCCAS 1-Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 No Yes 1 Yes director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

completely o the Hr. within ?

State Registrar

Medical

29a. Certifier

(Check

only one)

3 [

completed cause of death (Item 23a) (Type, Print) Name and address of pers M) 44T 31. Date filed (Month, Day 32. Registrár's Signature

LJ

NSE

1-🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

296 Date signed (Month, Day, Year)

NNATOLISM D LIYUI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ cw (20 Wa 0232 A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia **Funeral** 1 ₩ M 2 □ F Months 02/25/1927 231-16-5179 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Direct 1 Tes 2 H No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1290 White Sands Drive 20657 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Self Employed Dentist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Dorman Walton Fawley, Sr. Edna Cale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is 1290 White Sands Drive, Lusby, Maryland 20657 Marilyn Fawley / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 01/16/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Rausch Funeral home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurd. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition تجعيا Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): physician a resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending pi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 2 the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Director: After this certificate Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1 Anpatient 2 -ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral C Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) è D0061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Hospital Road, Prince Frederick, MD 20678 Chang Choi, MIS 1D+ 32. Registra s Signature

State

Registrar

D. Carles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#19 bperFH, 1/13/12; EWW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Adelaide Elizabeth Olsen Faehner 2012 5:50pm January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Assisted Living Facilities Adelphi Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days (Month, Day, Year) 110-46-4622 Director 1 □ M 2 X F 94 May 20, 1917 New York Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6416 Sandy Street 20707 u.s.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Olsen Adelaide Wasmer 19a. Informant's Name/Relationship (Type, Print) 64126 ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 i any injury or other tra Mark E. Faehner - Son 6116 Sandy Street, Lawrel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Union Cemetery 01/14/2012 | Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, dungun um 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Prerenal Azotemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): franch Grant Franch Fra Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Day Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the for Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce D0051897 January 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Chevrolet Drive. #100. Ellicott City, Maryland 21042 Njide Udochi. M.D

DHMH 17 Rev 06-2011

State Registrar d (Month, Day, Year) JAN 13 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evelyn Fishbein 9°ay 201Ž^{ea} January 7:50A. M Medical 4a. Facility Name (if not institution, give street and number) Renaissance Gardens at Riderwood 4b. City Town, or Location of Death Silver Spring Examiner Prince George's 5. Social Security Number 9. Birthplace (State or Foreign New International New Internationa 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🗆 M 2 😾 F 076-01-9681 92 JUNE21 1919 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rector Maryland Prince George's Silver Spring 1 ☐ Yes 2 No Ö 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 3160 Gracefield Road, RC1102 20904 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White 3 Divorced Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Centner Sarah Fergurhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Daniel E. Fishbein -son 307 Upper Gulph Road Wayne, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gdns. 1/11/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic Donard Wide Boffgwardt Funeral Home, PA 15 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Arteriosclerotic Cerebrovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a donsequence of) Exami ans. To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Pregnant at time of death the hed Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð Alzheimer's Disease Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I page 2 s autopsy perforn certificate rmed? 2 X No 1 Yes 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🔀 No Other: ျပ 4 XNursing Home 5 Residence 6 Other (Specify 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗌 DOA this funeral n 24 hours after death.

• Funeral Director: After th
pleted filled in by the funeral 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted 1 (Check within 2.

To the F
complet 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen GemmeII, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#19aperFH, 1/12/11; BMW, McGertificate of Death 2. Date of Death Physician/ 20/2 FIELMAN SALLY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTEOMERY GENERAL HOSPITAL OLNEY MONTOOMERY If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Hours (Month, Day, Year, **Director** 118-32-6018 1 🗆 M 2 🗶 F 78 4-30-1933 England Usual Residence of Dece 28a-f show 10b. Count 10c. City, Town or Location notified at Funeral Director 10d. Inside City Limits Maryland | Montgomery 01ney 1X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a 4513 Prestwood Drive 20832 United States 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner Race - American Indian q Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 No Specify. White Completed 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Legal Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jack Levitt Rose Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Fielman Husband 4513 Prestwood Drive, Olney, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem. Gardens 1-11-2012 Olney, Maryland 21. Signature of Funeral Service Licensee Kurt Blake 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 MO1477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a COMPLICATIONS OF Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 Ug Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Inpatient 2 MER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 01,08,2012 00060319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

68760

Box (

P.O.

of Vital

Division

31. Date filed (Month, Day, Year)

MO - 18101 Prince Philip Dr., Olney Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Day 2012 ear Charles R. Frushour 8 12:50p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 115 Woodside Avenue Thurmont Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 32 220-34-0915 79 Maryland Director Jan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Thurmont 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Woodside Avenue 21788 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck driver Cement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles E. Frushour Bertha E. Eigenbrode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21778Kenneth Frushour - Son 14922 Motter Station Road, Rocky Ridge, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial 1-13-2012 Frederick, Maryland 21. Signature of Funeral Service Leave ee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year Yes 2 🗌 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗖 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No. Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

0

State

31. Date filed (Month, Day

3

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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	11-000		

			1 - For State Registrar	State of W	iai yiai ia /		tificate of	Death		Reg. No		
		- 19	Decedent's Name (First, Midd	le, Last)					2. Date of De.	ath		3. Time of Death
	Physic /Medi		Florence Fon	taine					Month 1	6 Da	201 ^{Year}	8:56 a м
*	Exami		4a. Facility Name (If not institution)		4b. City, Town, o	r Location of Death		40	. County of Dea	ath	
			30711 Hampde				Princes				Somerse	
l	Funeral Director		5. Social Security Number 218-12-7038	6. Sex 7. A	ge (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 12-19	y, Year, -19	9. Bi	rthplace (State or Foreign country)
	and wo		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow must be notified at	jo	MD Some	ract	Daning		7					1 ☐ Yes 2 ☐XNo
	the rout	Funeral Director	10e. Street and Number	rset	PLINC	cess	Anne 10f. Zip Code			10g. Ci	itizen of What C	Country?
	3a ol		30711 Hampde	n Avenue			21853			USA		
	death	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. V		lispanic Origin? (Sp an, Mexican, Puerto			14. Race - Am	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examinal must be notified at		1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes 2 💆	No		Yes 2X No		nican, etc.)		Black, Wh SpecifyBla	
5-0	72 ho	eted	15. Deceder	nt's Education ast grade completed)	16	a. Deced	ent's Usual Occup	ation during most of work	dina	16b. F	Kind of Busines	s/Industry
2121	within ene. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or		life. L	OO NOT use retired	d) -	rg			
2	ygier ygier it,	ပိ	6		F	Ious	ekeepin				mestic	
and	be fill d ott	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	,	Maide	n Sumame)	
Yla	ould Mer nark	မ	Noah White					Sadie J	_			
Maryland	12 sh h and f is m		19a. Informant's Name/Relations					and Number or Rui				
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other treumatic event, The Magnee.		Anna Fontain 20a Method of Disposition	e/Daughter	20h Place	0 7 1	1 Hampd	en Ave,	Princ		Anne,	MD 21853
Baltimore,	ages nt of n : If It		1 Burial 2 □ Cremation		,		sition (Name of natory or other of	1			,	
Ħ	it. Pi		4 □ Donation 5 □ Other (5 21. Signature of Pineral Service		Supre	eme	Council	1-14	-2012	Pri	ncess	Anne, MD
Ba	Depa Depa Impo eny i	15	21. Signature of Parietal Service	Licensee		Bĕ	nnie Si	sithin917 ome Sal	w. IS	abe M	:11a St	11
			23a Part Enter the disease, o	r complications that cause	d the death. Do	not ente	r the mode of dvir	Office Such as cardiac	or respiratory at	rest	2100	Approximate
1			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.			9, 00011 00 0010100	or roopiiatory a			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		4)-	ASCVD					
	Examiner			Due to (or as	s a consequence	e or):						
	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	e of):						
	uted d ansit	E L	Cause (Disease or injury that initiated events	S .								
ó	exec an an	Exa	resulting in death) Last	Due to (or as	a consequence	e of):						
68760,	tificate be executed ig physician and as the burial-transit	cal		d.								
	ntifica ng ph as th	Jed	IE ECMALE.		1985					- 1		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of de Month	elivery Day Year
	that ned by deta	Y.	Part II. Other significant conditi	ons contributing to death t	but not resulting	in the un	derlying cause giv	en in Part I.	23e. Did to	obacco	use contribute	to the cause of death?
Records,	aquires en sigr ould be								10	Yes 2	2 □No 3 □ F	Probably 4 Unknown
ecc	lawre nasbe e 2 sho	Completed							24a. Was	OSV	prior to	autopsy findings available completion of cause of
E		performed? death? 1										
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medica examiner?	Hospital:			100	26. Place of Deat	h (Check only o	ne)		
o	Physician: this certificantal director,	P.	1 Yes 2 No	1 L Inpati	ent 2 ER/C			4 Li Nui Siriy no	ome 5 Resid			ecify)
-	Attanding Phy r death. ector: After thii by the funeral o	Certification;	1 ☑Natural 5 ☐ Pendir		ay Year)	. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	10W Into	ary occurred	
Division	ofeath. death. ctor: A y the fu	lca	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	iuny - At home 1	farm etro	et, factory, office	165 2 140	28f Location /	Street a	nd Number or F	Rural Route Number,
Ö	l or / efter Dire	ert	4 Homicide determ	building, e	tc. (Specify)	iaiii, 3110	et, raciory, office		City or Tov			in a rioute runner,
	spita nours nerel		29a. Certifier 1 Certifyir	ng Physician: To the best	of my knowledg	ge, death	occurred at the tir	ne, date and place.	and due to the	cause(s	s) and manner a	as stated.
	To the Hospital or Attenswithin 24 hours efter deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination a	and/or inv	estigation, in my o	pinion, death occur	red at the time,	date an	nd place, and du	e to the cause(s)
	To ti withi To ti	Σ	29b. Signature and title of certifie	or /	,		29c. Licens	e number		29d. Da	ate signed (Mor	nth, Day, Year)
				NIM			14	7094		1	/16/12	
-	5TC		30. Name and address of person	who completed cause of	death (Item 23a)		Print) V / 510 N	Sheet	- 5.	41.1.	3 BURY	MD 21804
	Sta Registr		31. Date filed (Month, Day, Year)	7 2012 32. Fegist	rar's Signature	L	0. 20. 8	<u> </u>		101	, , , ,	<i>V</i>
				7-7	14	1000	Shift married					

DHMH 17 Rev 1/2001

ORIGINAL

12-00561 Jymera Ford MD 21215-0036

2012 0241 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 20, 2012 **Medical Examiner** Jymera Denise Ford 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Allegany 309 Harrison Street Cumberland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Oct 2, 2007 2**X**F 218-79-6125 1___M 4 Usual Residence of Decedent 10b. County 10c. City. Town or Location must be notified at once. Allegany Cumberland Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 309 E. Harrison Street 21502 Funeral 11 Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. Black 1 Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 1 Yes 2 X No Specify: white f Yas, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) n/a 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) rtment of Health and Mental Hy rtant: If item 27 is marked of y or other traumatic event, the Be Tandra Lowery Jvmar Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 324 Furnace Street Cumberland Jymar Ford father 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimo permit. Page: Department o Important: injury or oth 1/25/2012 Oonation 5 (ther Specify Sunset Memorial Park <u>Cumberland</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he Physician failure. List only one cause on each line. /Medical a. Carbon Monoxide Intoxication and Thermal Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funcral Director: After this certificate has been signed by the attending physician and Physician/Medical x AMENDED 14, per fh, g927 5-2-12 sm UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed by a director, page 2 should be detach ć 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy performed Yes 2 ✔ No 25. Was case referred to medical 26.Place of Death (Check only one) director, å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject victim of accidental house fire Jan 20, 2012 1 Natural 0605 hrs 1 Yes 2 V No Pendina filled in by the 2 🗹 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 309 Harrison Street, Cumberland, MD determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 21, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

0924 hrs

10d. Inside City Limits

1 X Yes 2 No

MD 21502

Approximate Interval

Between Onset and

Death

Day

prior to completion of cause of

MD

Country MD

USA

ORIGINAL

DHMH 17 Rev 1/2001

State Registra

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

4 Homicide

29b. Signature and title of certifier

Ana Rubio MD.

32. Registrar's Signature

found: residence

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

arkel

(Specify)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

1105 Red Eye Rd. Lusby, Md.

January 23, 2012

OCME

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gantt Physician/ Margo Month 2012 Jan. 11:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Calvert **Examiner** 4b. City, Town, or Location of Death 528 White Sands Drive Lusby . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Oct. 27 1 - M 2 X F Year) 956 Director 220-66-6926 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Calvert Lusby MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Drive 528 White Sands 20657 USA 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian vvas Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event actions. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oscar E. Holland, Sr Inez Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Вох Solomons, MD 20688 Chandra Gantt/ daughter .0. 74 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) of God Cem. 1/21/2012 Lothian, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home \$108hon Dares Beach Rd., Prince Fred., MD20678 1451 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Divito (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Exami Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnations State Sta Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 4 Unknown cate has been signated by page 2 should by Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director, After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and dies to the ca usats) and manner as stater 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Near)

JAN 13 201

LRW

32. Registra/s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 01 19:19 Irma Antonia Garcia Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Director 1 🗆 M 2 💢 F none 07/18/31 E1Salvador 80 28a-f show 10a. State 10c. City, Town or Location items 23a or 28a-1 sno ner must be notified at 10b. County 10d. Inside City Limits Director DC Washington 1 √ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 439 Kennedy Str., N.W. 20011 Salvador and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. traumatic event, the Medical Examiner Armed Force Black, White, etc. ö 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 ¹X∣Yes 2□No SpecifySalvadorian If Yes Give Specify: "natural", 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6th babysitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rosa Edelmira Garcia Salvador Zelaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Jose Fredy Garcia (son Mill Rd.Silver Spring.MD 20906 Veirs 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Page 1 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Salvador 21. Signature of Fyneral Savice Licensee 22. Name and Address of Facility Bacon Funeral Home St,N ,Washington,DC, 20010 3447 ĪΛĪ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying l-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last as the burial the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L recardo.

Pregnant at time of death Ectopic pregnancy in the past 12 months? detached for Month Veal 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Nn မ 1 Inpatient 2 Renoutpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Mghth, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Bay, Year) herk,

1 2 2012

. Registrar's Signer

Forest Glen Road, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDDIE MORRIS GODWIN III 10:21 January **Medical** 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Hours Min (Month, Day, Year) **Director** 212-80-2034 1 № M 2 🗆 F D.C. 01/14/1960 51 Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland notified at Director 1 ☐ Yes 2🏝 No MD Frederick Adamstown 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n Funeral 21710 2435 Park Mills Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. "natural", or iter dical Examiner Black, White, etc. by 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) engineering <u>stationary engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Dolan Eddie M. Godwin, II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health Angela Godwin/wife 2435 Park Mills Rd., Adamstown, MD 21710 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 01/13/2012 | Frederick, MD Stauffer Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityStauffer Funeral Homes. P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Provident/ COMONANY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ g ☐ Unknown detached by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed I should be def þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law I has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tes မ 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Hospital Medical

State Registrar 29a. Certifier

only one)

29b. Signature and

31. Date filed (Month

Day, Year) theremo

WORTHINGTON

32. Rel

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Bonnie Fitleberg,

istrar's Signature

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SUITE

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0065201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GINAU Physician/ Month 01 8:50 A M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1128 Carrs Wharf Road Mayo 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 98 **Director** 214-01-9230 1 M 2 F Maryland July 26,1913 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d, Inside City Limits Director MD Anne Arundel Mayo 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1128 Carrs Wharf Road 21106 be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Wieckert William B. Royer 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter-1128 Carrs Wharf Road Mayo, MD 21106 Constance Schrom, <u>in-Iaw</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State January Baltimore, MD Woodlawn Cemetery 4 Donation 5 Other (Specify) 2012 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses Severna Park, MD 21146 495 Ritchie Hwy. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician csear disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of eted cause of death (Item 23a) (Type, Print) Name and address of page 31. Date filed (Month. JAN 1 3 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 1^{Day} 20T2 10:32 AM Judith Ruth House Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death La Plata Charles 5463 Well Spring Ct. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min. (Month, Day, Year West Virginia 68 Director 232-68-8355 Ĩ943 Usual Residence of Decedent John v.v., or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20646 United States 5463 Well Spring Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Groceries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be filed f Health and Mental H item 27 is marked ot ည Roy Arnold Miller Ruth Walter Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold House/Husband 5463 Well Spring Ct. La Plata, MD 20646 Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Miller Cemetery 1-20-2012 Webster Springs, W.VA. Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A Til CEcho M00945 St. Mary's Ave. Box 567 La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) nua Physician/ ancel Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death
Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending М Accident Suicide 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

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31. Date filed (Month, Day, Year)

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ohn Hancock, J	Jr.		of Maryland			nt of Health	and Men	tal Hygiene		201	0 0011
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Physicia	an/	Decedent's Name (First, Middle,Last)				_		2. Date of D	eath		3. Time of Death
ledical Exami	ner	John Hancock, Jr.						Month January	Day 20, 20	Year 012	1707 hrs
		4a. Facility Name (if not institution, give	street and number)			4b. City, Town	, or Location of	of Death	4	c. County of Death	•
		9805 Diggs Road				Faulkner				Charles	
Funeral		5. Social Security Number 6. Sex	7. Ag	je (In yrs. la	ast birthda	ay) If Under 1	Year If Unde	er 24Hrs. 8. Date of	Birth(MM	//DD/YYYY) 9. Birt	hplace (State or
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kus k		10a. State 10b. County		10c. City,	Town or	Location					10d. Inside City Limits
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Mar r 288	Director	10e. Street and Number				10f. Zip Coo	ie		10g. Cit	tizen of What Cour	ntry?
with the Maryland ms 23a or 28a-f sho be notified at once		9805 Diggs Road				2063	2		Un	ited Sta	tes
h wit	Funeral		Was Decedent Armed Forces?		S. 1			gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ameri White, etc.	can Indian, Black,
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after	þ	3 Widowed 4 Divorced	f Yes, Give Year or Dates:			1 Yes 2 X	No specify:			Specify: Whi	te
ours xem		15. Decedent's Education (Specify only	highest grade con	npleted)		cedent's Usual Occi ing most of working			16b.	Kind of Business/I	ndustry
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215-0036 be filed within 72 hours af ntal Hygiene. rked other than "natural ent, the Medical Examin		17. Father's Name (First, Middle, Last)					18.Mother	's Name (First, Middl	e, Maider	n Surname)	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other fraumatic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relationship (Typ	oe, Print)		19b. N	Mailing Address (S	treet and Num	nber or Rural Route N	lumber, C	City or Town, State	Zip Code)
MD id 2 sho lith and m 27 is sumati		Kimberly Fletcher/	Daughter		68	l3 Innesf	ree Wa	y Gainesvi	11e,	Virgini	a 20155
Titen I am		20a. Method of Disposition	7			isposition (Name of or other place)	cemetery,	Date	20c.	Location - City or	Town, State
ages of the It It		1 Burial 2 Cremation 3	☐ Removal from St	210	-	fe Cemete	r	01-25-201	2	In Diate	, Maryland
Baltimore, permit. Pages 1 at Department of Het Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	ee	I NE							
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Physician		Daniel T. Lindawood, Jr. 23a. Part I. Enter the disease, or complic	cations that caused	the death	Do not e	nter the mode of dy	ing such as c	ardiac or respiratory	arrest sh	ock or beart	, MD 20646 Approximate Interval
Medical		failure. List only one cause on each	h line. Athero	oscle	rotic	Cardiov	ascula	r Disease	comp	licated	Between Onset and
Examiner			y Hypothe			10000					Death
		or condition resulting in death) Due to (or as a consequence of):								1	
	6	Sequentially list conditions, If any, leading to immediate Due to (or as a nonsequence or)									
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	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
executed an and al - transi	4	d									
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60, ate b	sician/Medi	IF FEMALE:	23c. If yes, outcor	ne of pregr	nancy	19.000			23	3d. Date of delivery	-
rtific as th	a	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2	Fetal death	3 Ectopio	pregnancy		Month D	ay Year
OX (eath ce	<u>:</u>	1 Yes 2 No 9 Unknown	4 Pregnant at	time of de	ath 5	Other (Specify)					
the a	Phy		9 Unknown								
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the burn.	by P	Part II. Other significant conditions	contributing to deat	h but not re	sulting in	the underlying cau	se given in Pa		-		the cause of death?
ires that signed I be deta								[1_]	Yes 2	No 3 Prob	ably 4 🗹 Unknown
required the state of the state	Completed							24a. W	as an topsy		topsy findings available ompletion of cause of
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tal Recentificate ector, page		25. Was case referred to medical				26 D	loop of Dogth	(Check only one)	s 2h	No 1 ✔ Ye	s 2 No
Vital Rec ysician: The l his certificate l director, page	a	examiner? Ho	spital: 1 Inpatie	ent 2	ED/Outo	atient 3 DOA	i On	Nursing Home 5	7 Benid	6 - 1 0 th	
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ivisi lor At after d Direct	ij	3 Suicide 6 Could not be	9			, street, factory, offi	ce building, et	c. 28f. Location or Town	n (Street and State)	and Number or Ru 9805 Digg	ral Route Number, City
pital Di	Certification:	4 Homicide determined	(Specify)	Trail	ler E	lome		Fau1kn			
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Ŗ	29a. Certifier 1 Certifying Physician									
To the within To the complet	edical	one) 2 Medical Examiner:	On the basis of exa and manner stated,	mination ar	nd/or inve	stigation, in my opi	nion, death oc	curred at the time, da	ate and pl	lace, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier				29c. Lic	ense number		29d.	Date signed (Mor	nth, Day, Year)
		Carde HI	1 Qan	-		0.	C.M.E.		Jar	nuary 21, 2012	2
		30. Name and address of person who co	mpleted cause of c	leath (Item	23a)						
		Carol Allan, MD Assistan	t Medical Exar	miner 9	900 W.	Baltimore Stre	et, Baltimo	ore, MD 21223			
St	ate	31. Date filed (Month, Day Year)	32. Registra		re	back					
Regist		JAN 2 5 20	14 Lener	u ,	P. 1	9000					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 2012 Physician/ 11:18 P^M January Elizabeth S. Hemmick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Berlin Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Hours Months (Month, Day, Year) 31 SC 80 **Director** 213-30-5872 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 XNo Ocean Pines Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 66 Boston Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 Never Married 2 Married Yes 2 X No ð If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Secretarv Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hemmick, Eliza Baltimore, Maryland John Y. Southall Mary Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boston Dr., Ocean Pines, MD 21811 Thomas Hemmick/Husband 66 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State First State Crem. 1/18/12 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 21. Signature 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final massive disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ detached for in the past 12 months?
1 Yes 2 X No Month Dav Year Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ within 24 hours after death.

To the Funeral Director: After this certificate has been signi completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: Other: 2 X No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No (Month, Day, Year) injury 1 X Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe R 135131 January 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BA 10 State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10, 2012 Bernadine Headley 2:10 am January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Months Trinidad and 069-90-9835 **Director** 1 M 2 X F 59 April 18, 1952 Tobago Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD P.G. Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12306 Backus Drive 20720 USA Was Deceue... Armed Forces? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Black. 1 Yes 2 No Specify Specify "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Caregiver traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Unknown Theresa Springer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health au Important: If item 27 is any injury or other trau once. Amos Headley/Husband 12306 Backus Drive, Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) Tunapuna Public Cemetery 20a Method of Disposition Oc. Location - City or Town, State Tunapuna, Trinidad and Jan. 18, 2012 4 Donation 5 Other (Specify) Tobago 21. Signature of Funeral Service Censes Francis J. Collins Funeral 500 University Blvd. W., S Home Inc. Iver Spring, MD 20901 Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Breast Cancer Physician/ disease or condition resulting in death) vrs Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): T that initiated events resulting in death) Last Due to (or as a consequence of): burial physician sthe burial Physician/Medical SB attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ¶ 9 ☐ Unknown the Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🗓 No ဂ္ 1X☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation

Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. ompletely filled in by the

Baltimore, Maryland 21215-0036

2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number

Su/2 210

DHMH 17 Rev 06-2011

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State

Registrar

31. Date filed (Month, Day, Year)

JAN 13 2012

5 003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Kenneth Randolf Hamilton

2012	0242
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		1- For State Registrar	Ce	rtificate of	Death			Reg. No.	J 1 C 0 C 1 C
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of De Month	Day Year	3. Time of Death
ledical Exami	Iner Kenneth Randolph Hamilton January 9, 2012						2046 nrs		
*		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Prince Georges Hospital Center Cheverly Prince							
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Ye	ar If Under	24Hrs 8 Date of B		9. Birthplace (State or
Director			2_F 54	Yrs.	Months Da		Min	8/1957	Foreign Country) W • V •
		Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·						
м япу		10a. State 10b. County MD Prince Ge		, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō		ediges Rive	erdale					1 Yes 2 No
Mary 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	
Baltimore, MD 21215-0036 bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		6600 Furman Cour			2073			UnitedS	
th wii	eral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U Armed Forces?				n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Race White	- American Indian, Black, , etc.
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rrs aft nural"	٥	15. Decedent's Education (Specify only I	Dates:				ind of work done	16b. Kind of Bus	
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ID 21215-00; should be filed within and Mental Hygiene. T is marked other thatie event, the Med	å	Lon Hamilton Jr.					ine Jack		
D 21 should nd Me	은	19a. Informant's Name/Relationship (Type Linda Hamilton					per or Rural Route N		
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition		Place of Disposi			Riverda Date		20737 City or Town, State
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 Cremation 3	Removal from State Ft	crematory or oth	er place)		1/14/12	Brentwe	
t. Pag tment		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee						1	•
Balti permit. Departu Import		Wanda C. Baco	C- 4	22. N	ame and Addre	ss or Facility	W H Baco	n Funera	al Home
Physician	\dashv	23a. Part I. Enter the disease, or complica	tions that caused the death		47 14t	g, such as car	 NW Wa rdiac or respiratory a 	SNINGTOI rrest, shock, or hea	n DC 20010 art Approximate Interval
Medical		failure. List only one cause on each	_{line.} Iltiple Injuries						Between Onset and Death
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trans		d							
760, cate be execu physician and he burial - tra	Medical	UNPENDED	MENDED						
760, ficate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg 1 Live birth		-1 -1	Ectopic	prognancy	23d. Date of of Month	delivery Day Year
Box 68's death certification attending defor use as	ciar	past 12 months?	Pregnant at time of de	eath -	al death 3 er (Specify)		pregnancy	Wildright	Day Teal
Boy e deatl the att	Physician/	1 Yes 2 No 9 Unknown	9 Unknown				1.1		
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SiO Atten death ector: by the	cati	2 Accident Investigation	Jan 9, 2012 28e. Place of Injury - At h	1953 hrs				(Ctroot and Numbo	er or Rural Route Number, City
Division To the Bospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	(Specify) Major Roa		t, ractory, office	bullaling, etc.	or Town,		
Hospi 4 hour Funer ely fill		29a. Certifier 1 Certifying Physicians	To the best of my knowled		ed at the time,	date and plac			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: Or	n the basis of examination a d manner stated.	_					
7	Me	29b. Signature and title of certifier	a mainor stated.		29c Licer	se number		29d. Date signe	ed (Month, Day, Year)
		aus .			0.0	.M.E.		January 10,	, 2012
	1	30. Name and address of person who com							
			Medical Examiner	The second	4)	, Baltimor	e, MD 21223		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Re gis tr a r's Signa	ure back	. 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 19ay 2012 Kyungyong Ha 4:58 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11105 Suffolk Dr. Washington County Hagerstown 8. Date of Birth
(Month, Day Year)
Jan. 20,1931 If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 215-79-9340 South Korea Director 80 1 □ M 2 🛛 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Maryland Washington county Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11105 Suffolk Dr. 21742 U.S.A. "natural", or items dical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Korean 3 XWidowed 4 ☐ Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Mental Hygier Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked or other traumatic ever ဂ္ Sangkook Ha Hyuk In Kwan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heejeong Sun-daughter 11105 Suffolk Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 01-22-2012 Smithsburg, MD 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Diset and Death Immediate Cause (Final thyroid Metastatic Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any heading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day signed by the at i be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? ours after death.

eral Director: After this certificate hilled in by the funeral director, page Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 🗆 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D completely filled it Medical 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar ong

egistrar's Signature

perstown, Mad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-00288 Allen Heffner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

llen Heffner	State of Maryland / Department of Certificate of Ce		Reg. No. 2012 0242.		
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) Allen Lee Heffner	2. Date of Month	Day Year 2010		
iedicai =xammer	41. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death			
	6725 Kernal Court 5 Social Security Number	Frederick If Under 1 Year If Under 24Hrs. 8. Date	Frederick of Birth(MM/DD/YYYY) 9. Birthplace (State or		
Funeral Director	216-78-8428 1 _∞ M 2□F 50 Y	Months Dave Hours Min	/25/1961 Foreign Maryland Country)		
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation	10d. Inside City Limits		
	Maryland Frederick Freder		1 Yes 2 X No		
the Maryland or 28s-f sh iffied at once Director	10e. Street and Number	10f. Zip Code 21703	10g Citizen of What Country? United States		
with the us 23a c		Was Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian, Black,		
r death with or items 2. must be m	1 Never Married 2 Married Armed Forces? 1 Never Married 2 No	f Yes, specify Cuban, Mexican, Puerto Rican, et	Specify: White		
ural",	3 Widowed 4 Divorced in test, street 19/9-84	Yes 2 No specify: dent's Usual Occupation (Give kind of work done			
5-0036 ed within 72 hour 19 ygiene. other than "natu he Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retired)	Asphalt Company		
within giene. Medic	12 Truc	18.Mother's Name (First, Mi			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	George Heffner, Sr.	Helen Ellsro	ode		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a, Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Rou 5 Kernal Ct., Frederic	te Number, City or Town, State, Zip Code)		
G, M 1 and 2 Health Fitem 2	20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition crematory or Company of Company	obsition (Name of cemetery, other place) d Spires Jan. 16	20c. Location - City or Town, State		
Baltimore, permit. Pages 1 an Department of Hei Important: If ite	4 Donation 5 Other Specify:	emetery 2012	Frederick, Maryland		
Balt permit. Depart Import injury	21. Signatur 1 Uneral Struce Licensee	Resthaven Funeral Serv 9501 Catoctin Mountair	vices, Skkot Cody P.A. n Hwy. Frederick, MD 21701		
Physician	23a. Part I. Enter the disease or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac or respirat	ory arrest, shock, or heart Approximate Interval Between Onset and		
Medical	Immediate Cause (Fall disease a. Contact Shotgun Wound to the C	Chest	Death		
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
iner	if any, leading to immediate cause Enter Underlying Cause c.				
ted 1 unsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
50, te be executed ysician and burial - transit	d				
760, cate be physic the bur	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregnancy	23d, Date of delivery Month Day Year		
Box 68760, s death certificate be the attending physic of for use as the burnweician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3Ectopic pregnancy Other (Specify)			
). Box 6 the death ce by the attend ached for use	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death?		
P.O.		1	Yes 2 No 3 Probably 4 Unknown		
rds, require been si hould b		248	a. Was an 24b. Were autopsy findings available prior to completion of cause of		
Records, The law requires fracte has been signage 2 should be		1	performed? death? Yes 2 No 1 Yes 2 No		
Vital Rec ysician: The I his certificate b director, page	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one ient 3 DOA Other Nursing Home			
of Vision Physical Control of Con	1 V Yes 2 No The Impatient 2 Environment 28b Time	of Injury 28c. Injury at Work? 28d. De	escribe how injury occurred		
ion tending eath. tor: All the fur	1 Natural 5 Pending Jan 10, 2012 2 Accident Investigation	1 Yes 2 V No	ct shot self		
Division of Vital Records, spital or Attending Physician: The law requiremental briefly and the family briefly the fameral briefly the fameral director, page 2 should be certification. To Re Committed	28e. Place of Injury - At home, farm, s Suicide 6 Could not be determined (Specify) Single Family Hom	or	cation (Street and Number or Rural Route Number, City Town, State) Jernal Court, Frederick, MD		
ie be in		ccurred at the time, date and place, and due to t	he cause(s) and manner as stated.		
To the Ho within 24 To the Fu completely	one) 2 • Medical Examiner: On the basis of examination and/or investant and manner stated. 29b. Signature and title of certifier	29a License number	29d. Date signed (Month, Day, Year)		
	Aunth Grithall Mr	O.C.M.E.	January 11, 2012		
5xx	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Baltimore,	MD 21223		
り) Stat	31 Date filed (Month Day Year) 32 Redistrar's Signature		<u> </u>		
Registra	1881 4 0 0040 20 27	bash	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:45 A M 2012 Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annoupolis, MD Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Nov. 13 Days Hours Country) Alabama 011-16-9530 ^{Year)}1915 96 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-t snooner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director New 1 🔀 Yes 2 🗌 No Camden Chesilhurst Jersey 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 08089 105 Garfield Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ₩ Widowed 4 Divorced Black. Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eugene N. Haggans Willette Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. Jackson 38 Gentry Court, Annapolis, Maryland 20a. Method of Disposition 20c. Location - City or Town, State
West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of I-Important: If ite any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State Rolling Green 01/19/12 Pennsylvánia 4 Donation 5 Other (Specify) ²² Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perrvville, Maryland 21903-0766 21. Signature of Funeral Service Lac-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burlal-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? detached for Yes 2X No the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? 2 🔀 No 1 Yes 24 hours after death.

Funeral Director: After this certific sted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the P 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month D0065230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar arroth

Sohrab

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04711/2012 1540 Harry E. Heaphy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month. Dav. Year Baltimore, MD 220-18-8840 1 🕅 M 2 🗆 F Director 08/14/1926 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b County 10d. Inside City Limits 10a State 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Annapolis Anne Arundel 1 🗌 Yes 2 🙀 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21401 USA 2679 Cunningham Hole Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Armed Forces?

1 X Yes 2 No WWII Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify:White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Owner and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail the 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Andrezejewski Harry E. Heaphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 2679 Cunningham Hole Road Annapolis, MD 21401 Janet P. Heaphy Spouse 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or other place) 01/13/2012 Glen Burnie,MD Signature of Funeral Service Lice 22. Name and Address of Facility 12 Ridgely Ave Vat Hardesty Funeral Home P.A. Annapolis,MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) numun Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin the Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Yes 2 L been signed by the should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page 1 ☐ Yes 2 No certificate 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred After Matural work? 1 Yes 2 No iniury 5 Pending 24 hours after death.

Funeral Director: Aft Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gork

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Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 310 PM Harris 01 06 2012 **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5009 frankfordare Briltimore, MO 7. Age (In yrs. last birthday) N/A timore Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Hours Min. Ju Worth, Par 2 Year 935 Maryland 219-30-3776 76 Director Usual Residence of Decedent show be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 310 Sumner Rd. 21401 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 ☐
If Yes, Give 1 Black, White, etc. Completed by 1 Never Married 2X Married 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: IT Yes, Give 1960-80 Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry ige 1 and 2 should be filed within 72 h nt of Health and Mental Hygiene. Et if item 27 is marked other than "ni or other traumatic event, the Medii (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Bail Bond 12th 8vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Harris Sr Suzanne Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Sumner Rd. Annapolis, Md. 21401 Mary Harris(Wife) Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20a. Method of Disposition 20b. Plankochimostich (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 1-13-12 Davidsonville, Md. 4 Donation 5 Other (Specify) Mortuary, P.A. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MALNUTRITION disease or condition Medical resulting in death) **Examiner** SEVERE DEMEN Sequentially list conditions, Examiner ff any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Day Year Pregnant at time of death be detached g | Ilnknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC KIDNEY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? BILAT BLINDNESS 24a. Was an autopsy has MOIZNSTABAYH 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral c 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier my by 06 2012 DOOT0832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltim DR MD 21201 N EUTAW ST # 308 CD KIDDUGAVU MMAHOM

DHMH 17 Rev 7/2009

State

Registrar

JAN 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201^{rea} 11:30 AM Deryl N. Ingold January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 **X** M 2 □ F 76 Director 578–48–1195 Yrs October 7,1935 Durham, NC show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director Maryland Montgomery 28a-f Gaithersburg 1 ▼ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 120 Duvall Lane Unit 101 20877 United States permit. Page 1 and 2 should be filed within 72 hours after death in Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Caucasian If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Retirement Community Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jourdan Ingold, Sr. Esper Gunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Ingold, Spouse 120 Duvall Lane Unit 101, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 01/17/2012 Brentwood, Maryland Ft. 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Dicensee MO1102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 | Yes 2 L 9 | Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N After this certificate has director, page 2 Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate h 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 XNo 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one 29b. Signature and title 9 29c. License number 29d. Date signed (Month, Day, Year) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Chukwuemeka Chuke, 10401 Riverwood Drive, Potomac, Maryland 20854 31. Date filed (Month, Day, Year) State JAN 13 Registrar

Jobla, Dervi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Warren H. Johnson Jan. 2012 7:55A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Holy Cross Rahab.and Nursing Burtonsville <u>Montgomery</u> If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Birthpiac Country) NY 1 🔀 M 2 🗆 F Month Hours 08/31/1929 099 22 1851 82 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 No MD Prince George's College Park 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 10117 Rhode Island Ave. 20740 USA · death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give 1949-69 Year or Dates 1949-69 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 127 is marked other than er traumatic event, the Me filed within Elementary/Seconday (0-12) College (1-4 or 5+) Federal Police Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Johnson Marioria Vann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 is Jacqueline Johnson/Daughter 819 Triple J Rd.Berryville, VA 22611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1XXBurial 2 🗌 Cremation 3 🗌 Removal from State 1/20/2012 Crownsville,MD 4 Donation 5 Other (Specify) Veterans Cem. 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Lice 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ancreatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year detached the g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: P 1 Inpatient 2 I ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) è 00069829 5

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DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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2613.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANVARY Physician/ LAVERNE JESTER 07:30 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign **Funeral** 188-38-5854 Director 1 🗆 M 2 🗶 F 63 Yrs. JUL 03,1948 LEBANON, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX COUNTY MILLSBORO 28a-f 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a (Funeral BETHEL ROAD (GUMBORO) 22854 19966 UNITED STATES items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. or, "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene.
7 is marked other than traumatic event, the M Elementary/Secondary (0-12) NURSING HOME & College (1-4 or 5+) ACTIVITIES DIRECTOR REHAB. FACILITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marke WILLIAM RECHT LUZILLE ARNOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMIE MASTERS (DAUGHTER) 22854 BETHEL ROAD, MILLSBORO, DELAWARE 19966 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) EBENEZER UMC CEM. JAN 21,2012 LEBANON, PENNSYLVANIA of Funeral Se 22. Name and Address of Facility 19966 Tober WATSON FUENRAL HOME PO BOX 125, MILLSBORO, DE MO 1361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ENDOLARDIZIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as. IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death 5 Other (specify) Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 No Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 2 💢 No Yes 2 X No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 X No မ 1 X Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? s after death. 1 X Natural 5 Pending 1 Yes 2 No Accident the Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide

within 24 hours a To the Funeral I

Hospital

State Registrar

filled in by

Medical

29a. Certifier

29b. Signature and title of certifier

Dant 1%

30: Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARGIAND MEDICAL CENTER

M.D

determined

32. Registrar's Signature,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number 725582

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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22 SOUTH GREENES ST. BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year DHNSON 10:10A 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Burtonsville 4c. County of Death Montgomery **Examiner** Holy Cross Rehab & Nursing Cen Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 2 1/2 15 1/2 1/2 2 2 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) S.D. 466-28-9990 1 □ M 2 🖾 F Hours 89 Director Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 Funeral 15200 Centergate Drive USA ural", or iten 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 er than "natural", the Medical Exar 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Elementary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | 2 Alta Finley Fred Robertson 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Sheela Stuart-Ammons/ 15200 Centergate Drive Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 B Removal Mizpan Cemetery 1/14/2012 Plankington, S.D. 5 Other (Specify) Service License PHIMITIPHE SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line Interval Between Immediate Cause (Final ARDIOMUOPATH Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 🗌 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Day ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ EBILITY Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PRESSION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 💆 work? Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) N 28571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ASNEEM 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 13. ORIS DARE JOHNSON 2012 5:00 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING HOME **QUEEN ANNE'S** CENTREVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** MARCH 7 1 🗶 M 2 🗆 F Months Days Min Director WEST VIRGINIA 1935 233-54-8468 76 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 64 LONG CREEK DRIVE 21666 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1954–1974 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. UNITED STATES Elementary/Seconday (0-12) 12 College (1-4 or 5+) SECURITY POLICE AIR FORCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o permit. Page 1 and 2 should be f. Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ဂ္ UNKNOWN BESSIE HENDRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 LONG CREEK DRIVE, STEVENSVILLE, MD 21666 SIGRID WINK JOHNSON/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ST. PETER S CATHOLIC 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) QUEENSTOWN, MD CEMETERY Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine 2225 To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Physician/Medical years Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2 No Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifler 16-2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Louise Woodworth Kaplan 6 P^{M} Medical 1:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours Min. 1-26-1923 Country) Director 579-22-6006 88 IL Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number ö 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 3118 Gracefield Road CC-512 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Je filed win. Tatal Hygiene. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygier 7 is marked other t Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Woodworth other traumatic Louise Gowdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Attach Marilynn K. Anton - Daughter 20061 Doolittle St., Montgomery Village MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 1/9/12 Falls Church, Virginia King David Mem. Gardens 21. Signature of Funeral Service Licensee Melissa Greenhut #M01597 22. Name and Address of Facility Danzansky-Goldberg #M01597 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pneumonia Days Medical resulting in death) Due to (or as a consequence of) Examiner Bronchiectasis Years Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 phys the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Month Dav Year Pregnant at time of death the hed 9 🔲 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2LAN, LCUISEVDivision of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Yes 2 X No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 5 Pendina within 24 hours after death.

To the Funeral Director: A

completed filled in by the fi Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Datq signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD., 8600 Old Georgetown Rd., Bethesda, Maryland 20814 Melissa Lynn Means, 31. Date filed (Month, Day, Year) **JAN 13** 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1-6-2012 1300PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 0 1 Physician/ 09 2012 Year Thomas Linburg Keene 12:00pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater DC Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1072271927 226-36-0099 Director Virginia 84 Usual Residence of Decedent 28a-f show items 23a or 28a-f sho her must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road 20851 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Manager Retail - Grocery 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Tom Keene Bessie Roher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Keene (daughter) 13301 Avebury Dr Laurel, MD 20708 Apt #14 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln 01/20/12 |Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WH Bacon Funeral Home Wanda C. 3447 14th St NW Washington DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Metastatic Cancer -Physician/ Prostate disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d Date of delivery in the past 12 months? Year Dav Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably M Unknown has been sign 2 should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, pag 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 X Natural 5 Pending work 1 Tes 2 🗌 No Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier mina 1-9-2012 Doo 64871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville 6121 Fazli, MD Rd Montrose

State Registrar

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JEANNE 0. KIDDER 11:10 A M 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner a is Wicomico Huspice 8. Date of Birth (Month, Day, Year) ear If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 410-44-2625 1 ☐ M 2**X** F Director 2-24-1929 Tennessee 82 Usual Residence of Decedent show 10c. City. Town or Location 10d. Inside City Limits 10b. County Director notified 28a-f Delaware Sussex Seaford 1 🛛 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? ъ 10e. Street and Number must be Funeral items 23a 900 heritage Dr 19973 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ъ by 1 Never Married 2 Married Yes 2 🔀 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ✓ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Home owner Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Merilyn Smith Edwin T. O'Donnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12410 Huntington Woods Ave Spring Hill, 19a. Informant's Name/Relationship (Type, Print) Phillip Kidder - son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 01/16/2012 Dover, DE 4 Donation 21. Signature / f Funeral 22. Name and Address of Facility Cranostn Funeral Home Box 967 Seaford, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YMDHOMP Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter or darlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 Yes 2 No Watural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHORE DR SALISBURY 910 Registrar

Ranne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Catherine Theresa Lorden Linuary 401 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number 8. Date of Birth April 20,1927 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 216-20-2264 Min. Hours **Director** 1 □ M 2 🗓 F 84 Maryland show at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Washington County ms 23a or 28a-f s must be notified Maryland Hagerstown 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 251 Sunbrook Lane 21742 U.S.A. ural", or items a 1 and 2 should be filed within 72 hours after death v f Health and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced Year or Dates injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas J. Keavney Mary A. Bourke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry F. Lorden-husband 251 Sunbrook Lane Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 1-19-2012 | Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law this certificate has performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 ☐ Inpatient 2 🌠 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau..

To the Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 18

Registrar
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State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UND

WATERD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 3 John Lucero, Jr. January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Community Hospital Prince George's Lanham Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Director 521-66-0704 1 M 2 D F 64 Usual Residence of Decedent Dec. 22, 1947 Colorado 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f MD Prince George's Greenbelt tycycyes 2 No 10e. Street and Numbe 10f. Zip Code o 10g. Citizen of What Country? ms 23a or must be Funeral 6938 Hanover Parkway #301 20770 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 Yes 2 No Specify White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John S. Lucero, Sr. Macedonia Lucero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan B. Lucero / Spouse 6938 Hanover Pkwy., #301, Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hephzibah Baptist Cem 1/14/2012 East Fallowfield, PA Signature of Juneral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Part 1. Enter the disease, or co-shock, or leart failure. List only Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į, in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 perform 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ▼No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature D70967

Registrar

DHMH 17 Rev 06-2011

State

ed cause of death (Item 23a) (Type,

				Department of Health and N Certificate of Death	1ental Hygi	•				
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are a	Physicia Medic		Paul Richard Lecates		Month © 1 -	12-3011 6:37 AM				
	Examir	ner	4a. Facility Name (if not institution, give street and number) Coastal Hospics at the Lake	4b. City, Town, or Location of Death Sulisbury		4c. County of Death Wicomico				
- W. C.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign				
Ы	Director			Months Days Hours Min. Yrs.	(Month, Day, Y March 6,	(ear) Country)				
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	a or 2 be no		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?				
	th with ms 23 must	Funeral	30494 Gordy Mill Road	21875		U.S.A.				
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Maryland 21215-0036	2 shouth and the and the strain traum			. Mailing Address (Street and Number or Rura						
ē,	f Heal item ? other		20a. Method of Disposition 20b. Place of	0494 Gordy Mill Road Disposition (Name of		MD 21875 Oc. Location - City or Town, State				
mo	Page nent o ant: If Iry or		The state of the s	y, crematory or other place) s Family Cem. 1-16-		Delmar, Delaware				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Short Funeral Home	ZUIZ	DOLLARY DOLLARGE				
	0.0 = € 0		23a. Part 1. Enter the disease, or complications that caused the death. Do no	13 East Grove Stre		mar, DE 19940				
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Division of Vital Records,	or Attending Physician: The law after death. Director: After this certificate has I in by the funeral director, page 2	Certificate:	Z		28f. Location (Stree	et and Number or Rural Route Number,				
Ω	ital or urs afte ral Din lled in		building, etc. (Specify)		City or Town, S	·				
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.				
	To the within To the comple	Σ	only one) 3 ☐ Certifying Nurse Practitioner: To the best of my know 29b. Signature and title of certifier	ledge, death occurred at the time, date and plant 29c. License number		ause(s) and manner as stated. 1. Date signed (Month, Day, Year)				
			• (00058400		01/12/12				
	250		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	1	up 2.1802				
	Stat	6	31. Date filed (Month, Day, Year) 32. Registrar's Signature	P 1/33 SA 138	they o	40 2/0 L				
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Paul R. Lecates

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irving Sturgis Mumford III Jath. 14Day 2012 6:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12909 Center Drive Ocean City Worcester Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days 1 **X** M 2 □ F Country) **Director** CA 218-20-4410 87 10-11-1924 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Worcester Ocean City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral USA 12909 Center Drive 21842 death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 No Specify: Completed 3 ₩idowed 4 Divorced white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Tackle Store 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Irving S. Mumford Elizabeth S. Dickinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel R. Mumford- Son 13048 Riggin Ridge Rd. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If it any injury or or 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) First State Crem. 1/16/2012 4 Donation 5 Other (Specify) Millsboro, DE 21. Signature of Funeral Services ice 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ne. Approximate Interval Between Onset and Death Immediate Cause (Final Ph.sici.n. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examir -transit resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Pregnant at time of death Month Year 2 No 1 Yes 2 L 9 Unknown ed by the a Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has, autopsy page perform death? Hospital or Attending Physician: The this certificate Yes 2 1 🗌 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director; After director of the further of the f 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after d

To the Funeral Direct
completed filled in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier [PCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29d. Date signed (Month, Day, Year)

JH 941

State Registrar

DHMH 17 Rev 7/2009

of death (Item 23a) (Type, Print)

32. Reginar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 () | 2

			For State Registrar	State of Mary		artment of F tificate of D		ivientai Hy	gierie Reg. No. 2 ()	12 02439
	Physicia	n/	1. Decedent's Name (First, Middle, L	· .				2. Date of De _ Month	ath	3. Time of Death
ي معادد	Medic Examin	al	Mary Eva 4a. Facility Name (if not institution, gi	Murphy ve street and number		4b. City, Town, or	Location of Death	Januar	y 9, 2012	
mer!	LAGIIIII	E	9913 Ferndale Av			Columbia		,	How	
	Funeral				yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		405-26-3048 Usual Residence of Decedent	1 □ M 2 🖾 F 85	Yrs.			Oct. 17	, 1926	KY
	yland f shored at at	itor	10a. State 10b. County	100	c. City, Town or Loc	cation				10d. Inside City Limits
	e Mar r 28a- notifi	Director	MD Howard 10e. Street and Number		Columbia	10f. Zip Code			10a. Citizen of V	1 ☐ Yes 2 ☒ No
	with th	Funeral	9913 Ferndale	Avenue			1046		USA	vnat Country?
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎘 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	11	Vas Decedent of Hi f Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race Black	e - American Indian, k, White, etc. White
Baltimore, Maryland 21215-0036	thin 72 ho ene. than "nat he Medica	Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)		(Give F	lent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of wor.	king		siness/Industry
d 2	Hygie other ent, t	Be	17. Father's Name (First, Middle, Last)	Homem	aker	18. Mother's Nan	ne (First, Middle,	Maiden Sumame	Home.
ylan	d be fi Mental arked atic ev	70	William Cooper	Cawthon			Eva Becl	k		
, Mar	and 2 shoul Health and I tem 27 is m		19a. Informant's Name/Relationship James Murphy/			ng Address (Street a				
imore	Page 1 arment of Hicant; If iter		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 4 🔲 Donation 5 🗍 Other (Spe	Removal from State	ob. Place of Dispos Arlington	sition (Name of natory or other place n Nationa Cemetery	ျ Ja	n. 25, 2012	20c. Location - Arlingt	City or Town, State
Balt	permit Depart Import any inj	10	21. Signature of Funeral Service Lice	the My		rancis J. D Univers	s of Facility Collins 1ty Blvd	Funera	l Home I	nc. ring. MD 20901
المر	h sician/		23a. Part 1. Enter the disease, or co shock, or neart failure. List only Immediate Cause (Final	one cause on each line.		er the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
a sel	Medical Examiner		disease or condition resulting in death)	Due to (or as a cor	sequence of):					
	Examiner	er	Sequentially list conditions,	b. Cerebrova:		Lsease				10 yrs
	ted Casit	edical Examiner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or as a con	isequence oi).					
	ian and	EX.	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
760	ficate be executed g physician and as the burial transit	dice		d						
Division of Vital Records, P.O. Box 687	Hospital or Attending Physician. The law requires that the death certific 42 hours after death. Funeral Director: After this certificate has been signed by the attending etely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome of profile 1 Live Birth 2 1 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Dati Mor	e of delivery hth Day Year
Ö.	nat the ed by i detacl		Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
S, F	uires t n sign	ed by	Hypertension, O	rthostatic Hy	potensio	n,		1 🗆	Yes 2X No	3 ☐ Probably 4 ☐ Unknown
Sorc	aw req as bee 2 sho	Completed	Seizure Disorde	r				24a. Was		Vere autopsy findings available
Rec	Physician: The law this certificate has ral director, page 2	Con						perfo	rmed? d	eath? ☐ Yes 2 ☐ No
ita	s ician certifii rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Tothe	ace of Death (Chec			
1 Inpatient 2 ER/Outpatient 3 DOA Confer: 4 Nursing Home 5 28d. Date of injury 1 Natural 5 Pending 28d. Date of injury (Month, Day, Year) 28b. Time of injury work? 1 Yes 2 No 1 Yes 2 No 1 Nursing Home 5									dence 6 - Othe	1
28d. Describe how injury of the property of th									r or Rural Route Number,	
	To the Hospits within 24 hours To the Funera completely fille	Medical	(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my k niner: On the basis of examin rse Practitioner: To the bes	ation and/or investi	igation, in my opinio	n, death occurred a	at the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the with com		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 1/11/2012							
	•		30. Name and address of person who				.01 -			
	Stat	e	Hubert Alpert, 31. Date filed (Month, Day, Year)		ignature	Drive, #4	+UI, Beth	nesda, M	ற 20817	
	Registra		JAN 12 20	12 /2	A. 40	1000				

DHMH 17 Rev 06-2011

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hn Mongan, J	r.	State of Maryland / De			nd Mental H	lygiene		201	2 0244
		1- For State Registrar	ertificate	of Death			Reg. No.	2011	_
Physici	an/	Decedent's Name (First, Middle,Last)			-	Date of De Month		V	3. Time of Death
ledical Exami	ner	John Glenn Mongan, Jr.				January	Day 13, 201	Year 12	1253 hrs
*		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of Deat	h		County of Death	
		11004 Clinton Avenue		Hagerstow	/n		V	Vashington	
Funeral		5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday) If Under 1 Ye	ear If Under 24Hr	s. 8. Date of B	irth(MM/	DD/YYYY) 9. Bir	
Director		213-31-6998 1\(\textbf{M} \) 2\(\textbf{F} \)	21	Months Da	ys Hours Min	1.	1	Foreig	n ^{untr} Maryland
		Usual Residence of Decedent	21	113.		JUCTOR	er 1	8,1990	Maryland
u			ity, Town or Lo	ocation					10d. Inside City Limits
*		Maryland Washington		II					1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	Maryland Washington 10e. Street and Number		Hagerst 10f. Zip Code	COMU		10a. Citiz	zen of What Cou	ntry?
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th the 23a o	의	11004 Clinton Avenue			21740				5A
th wi	Jers	11. Marital Status 12. Was Decedent Ever in Armed Forces? Armed Forces?	10.S. 13.	Was Decedent of H If Yes, specify Cuba			°-	White, etc.	can Indian, Black,
r dear	Funer		3000						White
raffe	ģ	3 Widowed 4 Divorced If Yes, Give Year 2008—2		Yes 2X N				Specify:	
hour:		15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occup g most of working lif			16b. K	(ind of Business/I	ndustry
n 72	š	Elementary/Secondary (0-12) College (1-4 or 5+)							
5-0036 led within 72 hours Tygiene. other than "natur	Completed	12	Appr	entice El					Company
Hyg Hyg	ŭ	17. Father's Name (First, Middle, Last)			18.Mother's Nam		Maiden	Surname)	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	John Glenn Mongan, Sr.	1.0			Renee		shner	
hould M His m	7	19a. Informant's Name/Relationship (Type, Print)		iling Address (Stre					
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 28s-f she traumatic event, the Medical Examiner must be notified at once		Sheila Kershner - Mother		W. Main					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medic		20a. Method of Disposition 20 1 Burjah 2 Cremation 3 Removal from State		position (Name of control of cont	emetery,	Date	20c. L	ocation - City or	rown, State
Page ent o		4 Donation 5 Other Specify	edar La	wn Mem. F	ark Jan	.18,201	2 Ha	gerstown	, Maryland
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		21. Signature of Funeral érvícé Licensée	le	SHOLITE ACTIVE	merely Ho	me, P.A	<i>A</i>		21795
E E S E		(in / / 1 / 1		25 S. Con				amsport,	Marvland
Physician		23a. Fart I. Enter he isease, or complications that caused the dec	ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rest, sho	ck, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (Oxy	codone	and oxymo	orphone)	intoxio	atio	ıπ	Death Death
Examiner		or condition resulting in death) Due to (or as a consequence of):							
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Box 68760, death certificate be the attending physic d for use as the bur	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the	egnancy 2	Fetal death 3	Ectopic pregn	ancv		I. Date of delivery Month	y Day Year
certinendin	cia	past 12 months?		Other (Specify)		,			,
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at the tache		Part II. Other significant conditions contributing to death but no	ot resulting in t	he underlying cause	given in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
P.O.	b S					1 Y	es 2	No 3 Prob	ably 4 🗹 Unknown
ords, w requires been should	ě					24a. Was			topsy findings available
COT law I has t	힅			· · · · · · · · · · · · · · · · · · ·			ormed?	death?	ompletion of cause of
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici piletely filled in by the funeral director, page 2 should be detached for use as the burn	ဥ	1 ✓ Yes 2 No	ER/Outpat		1		_	nce 6 🗸 Other	Scene
J Of Jing Pl After funera	ᇙ	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time		ury at Work?	28d. Describe	: now inju	ry occurred	
ttend death ctor:	ä	2 Accident Pending Fd I-13-12		42 рш	Yes 2 X No	unknow			
Division lal or Attendiu rs after death.	崩	3 Suicide 6 X Could not be 28e. Place of Injury - A			building, etc.	28f. Location or Town,	(Street al State)	nd Number or Ru 1004 C1:	ral Route Number, City Inton Ave.
Divi	Certification:		nd at h	nome		Hagers	town	, Md.	
e Hos 124 h e Fun etely		29a. Certifier (Check only 1 Certifying Physician: To the best of my know							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examinatio and manner stated.	n and/or invest			at the time, date			
	Σ	29b. Signature and title of certifier			ise number			Date signed (Moi	•
		Hate () - Holla		0.0	.M.E.		Jani	uary 14, 2012	2
		30. Name and address of person who completed cause of death (If	em 23a)						
0-Wt		Patricia Aronica-Pollak MD. Assistant Medica	al Examine	900 W. Balt	imore Street, I	Baltimore, N	1D 212	23	
	ate	31. Date filed (Month, Day Year) 32. Registrar's Sign	ature /	1 . 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 752 PM Porfidio Molina Torres January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days **Director** 581-76-7240 1 X M 2 🗆 F Feb. 28, 1942 69 Puerto Rico r 28a-f shorn 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No Hagerstown MDWashington 10e. Street and Number ō 10f. Zip Code ms 23a or must be r 10g, Citizen of What Country? Funeral 406 W. Washington St. Apt.2 21740 U.S.A. items (12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or iten ledical Examiner r 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 😾 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican White Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) at of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Justino Molina Catalina Torres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jose A. Molina/Son</u> 13821 Long Ridge Dr., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Department of Importants If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/18/2012 Hagerstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ardio pulmonary disease or condition resulting in death) ône hour Medical Due to (or as a consequence of): **Examiner** Acute myocardia Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Examine Cause (Disease or injury Coronary arlery attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Preumothorax 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic obstructive lung Osscare 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Cardiae dysyly tunn Hospital or Attending Physician: The 24 hours after death. Funeral Director; After this certificate I 1 Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 2 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a

To the Funeral E

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D44996 Tanuary 14, 2012 in (Item 23a) (Type, Print)
20311 Cappans Rd Burnston MD 21713 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-3 gistrar's Signature 31. Date filed (Mont) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Flora May Malin GNUCYL Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Grace Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day ec. 27 219-14-2362 1 □ M 2 🔯 Months Hours Min. Country) Maryland 88 Director Usual Residence of Decedent f show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director Havre de Grace Maryland Harford 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 U.S.A. 212 South Stokes Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🕅 Widowed 4 🗌 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Twelve Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Cameron Harris Flora Esther Williams Page 1 and 2 should Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Brown (Daughter) 6777 Ward Parkway, Melbourne Village, FL Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State West Chester, 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Ind. 01/15/12 Pennsylvania permit. 21. Signature of Funeral Service Lice Lee A. Patterson & Son Funeral Home, P Perrvville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Connun disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ama Econentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the 1 ☐ Yes 2 ≥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? puntin 24a. Was an certificate has autopsy performed? 2 🔀 No ☐ Yes 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Hospital: 2 JNo Other: ၉ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours a Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 h To the Fur (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one)

State Registrar 29b. Signature and title of certifier

P9100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

awil

29d. Date signed (Month, Day, Year)

Wn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Albert Mrozek A. January 12, 2012 8:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Genesis HealthCare Anne Arundel Severna Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F Director 218-26-5357 81 09,1930 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Y is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Addal Examiner must be notified at Director MD Anne Arundel Severna Park 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 602 McKinsey Park Drive # 203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1951— If Yes, Give 1954 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ģ 1 □Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Building Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Joseph Paul Mrozek Angela Polanowski Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Mrozek / Wife 602 McKinsey Park Drive # 203 Severna Park, MD 21146 January 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 20, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cemetery 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 No. the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: sertificate has autopsy 2 □ No 1 ☐Yes 2 ☐No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 ☐ Yes 2 🖾 🗥 o Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manufer of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a, Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

31. Date filed (Month, Day, Year) JAN 1 3 2012 Registrar

29b. Signature and title of settlifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandeep Pandove, M.D. 8601 Veterans Hwy, Suite 204 Millersville, MD 21108

29c. License number

D0048244

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Estelle O. Milburn January 2012 1:52 PM n. Facility Name (if not institution, give street and number) 1986 Valley Road 4c. County of Death
Anne Arundel 4b. City, Town, or Location of Deat Annapolis cial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 215-34-8174 Months oct. 27, Year 1917 94 Maryland 1 □ M 2XXF 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 X No 1986 Valley Road 10f. Zip Code 10g. Citizen of What Country? 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 X No Yes Yes Yes, Give 1 ☐ Yes 2 X No Specify. White 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard A. Owens Hazel Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Clark/son 317 Cedar Lane Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 1/17/2012 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Signatur dol 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician/ Medical Examiner

attending physician

Division of Vital Records, P.O. Box 68760

Department o Important: If any injury or

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

notified

pe t 23a

with the Maryland

Examine the burial-tra Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be to within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hourism. use as the a signed by the Certificate: To Be Completed by page 2 filled in by the funeral director,

Medical

29a. Certifier (Check

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of): Due to (or as a consequence of): C.	20 years
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in	n Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☒No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		of Death (Check only one)
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	□ Nursing Home 5 Residence 6 □ Other (Specify)
27. Manner of Death 1 💆 Avatural 5 🗆 Pending 2 🗀 Accident Investigati 3 🗆 Suicide 6 🗀 Could not	28a. Date of injury 28b. Time of injury at work? on M 1 □ Yes	28d. Describe how injury occurred 2 \subseteq No
4 Homicide determine		28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

bihso

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

City or Town, State

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1 Decedent's Name (First Middle Last) 3. Time of Death 3:47 A 2. Date of Death Physician/ Month A_{M} Medical RANDOLPH LEE McGOWANS 01/09/2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. Hours Min. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Davs (Month, Day, Year, Director 66 1 **X** M 2 □ F 216-44-6554 Yrs MARYLAND 07-14-1945 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 29-A HICKS AVE 21401 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other the RETAIL STOCK CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN P. McGOWANS other traumatic ALICE J. LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or and MARY MOULDEN/SISTER 31 HICKS AVENUE ANNAPOLIS, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BESTGATE MEMORIAL /13/2012 Donation 5 Other (Specify) ANNAPOLIS Facility LASTING TRIBUTES FELLOWS, INDICATE TO THE TRIBUTES FUNERAL CARE THAT TO THE TOTAL CARE TO THE TOTAL TO THE TOTAL CARE TO THE TOTAL TO THE T 21. Signatu of Luneral Septice Lice on 1. Enter the disease, complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Year Pregnant at time of death signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 **N**o Other: မ ER/Outpatient 3 DOA Impatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After the 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

32. Registrar's Signature

1) make Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 10 SHARI MARIA MARRA 2012 11:15 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 ី🗴 Days Min. 0270571951 WEST VIRGINIA **Director** 60 232-84-3980 Yrs. Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD OUEEN ANNE'S STEVENSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 350 BATTS NECK PLANTATION UNITED STATES 21666 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Importants if flew Z7 is marked other than 'any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATION COLLEGE ATHLETICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM M. MARRA JOANNA TORCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOEY M. ADAMS / SON 350 BATTS NECK PLANTATION, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State CEMETERY ST. 4 Donation 5 Other (Specify) 01/16/2012 QUEENSTOWN, MD Signature of Funeral Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Physician/ disease or condition Medical resulting in death) Examiner house otic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (o as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 1 🗌 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 UU 31. Date filed (Month, Day, Year) State 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 3. Time of Death C 2. Date of Death Month January 24, 2012 **Physician** 3:00 M Emma Jean Matthews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 18007 Lower Georges Creek Road SW Barton Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 6. Sex **Funeral** Country Maryland Months Days Hours Min. 1 □ M 2 X F 212-32-8164 78 February 10, 1933 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Exprimer mat Le notified at any Injury or other traumatic event, Ire Medical Exprimer mat Le notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XYes 2 ☐ No Director Barton Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21521 USA 18007 Lower Georges Creek Road SW Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Beeman Sampson Muir 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Pershing Street, Lonaconing, Maryland, 21539 Janell Lamberson - Niece Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date January 25. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland, Maryland **Cumberland Crematory** 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final orons **Physician** in disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by cate has been significated be to page 2 should be to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2 2 100 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. filled in by the I 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of iviaryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decement's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 8:20 P. M January Alice Joyce Nobles Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 M 2 X 0970474926 North Carolina **Director** 239-36-9506 85 Usual Residence of Decedent or 28a-f show ye 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1960 Owensville Court 20754 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Specify: white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) subject cataloger Library of Congress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gardner Josephine Tilghman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry W. Nobles, son 1960 Owensville Court, Dunkirk, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 s 1 57 Burial 2 Cremation 3 Removal from State any injury or Important: Smithville Cemetery 01/15/2012 Donation 5 Other (Specify) Dunkirk, MD Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the gisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph sician/ 1)47 disease or condition resulting in death) Medical Due to (or as a consequence of) Examine DAY EUMONIA Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 № No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 Tes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 140 Other: မှ 1 Hipatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending Accident
Suicide 1 Yes 2 No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year,

State

Registrar

32. Registrar Signature

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JANUARY** MARY ELLEN LANIER PROCTOR 2012 15:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Director 579-82-4992 1 □ M 2 🏋 F 48 JANUARY 2, 1964 VIRGINIA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20744 3017 MARQUIS DRIVE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: BLACK 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) RETAIL SUPERVISOR TRAVEL AGENCY Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည HENRY RUDD SYLVIA JEAN LANIER STEVENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY LANIER / SISTER 4665 GADWELL PLACE, WALDORF, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) RESURRECTION CEMETERY JAN. 20, 2012 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Sature of Funeral Service Literasee THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phirsteam ACUTE INFAR CITON MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CORONARY DISTASE ARTERY Sequentially list conditions, Examine Due to (or as a consequence of): it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death 1 Yes 2 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABBTES 1 Yes 2 No 3 Probably 4 Dunknown HEMORRHAGIC STROKE 24b. Were autopsy findings available 24a. Was an autopsy performed? 1 Yes 2 W prior to completion of cause of death? 2 UNO 1 Yes To the Funeral Director: After this certifics completely filled a by the funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No |요 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D 29a. Certifier Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0064986 1/16/2012

DO /U

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Samuel David I		1- For State Registrar		tment of I ficate of L		id Mental I	F	Reg. No. 201	2 0245
Physic Medical Exam		1. Decedent's Name (First, Middle, Last) Samuel David Pounds,	Tag				Date of De Month	Day Year	3. Time of Death 1555 hrs
- Courtour Exam		4a. Facility Name (if not institution, give street and number		4b	. City, Town, or	Location of Dea	January :	4c. County of De	
		Sinai Hospital			Baltimore			,	
Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. łast	birthday)	If Under 1 Yea		_	irth(MM/DD/YYYY) 9. I	
Director	1	589-56-1608 1XM 2_F	66	Yrs.	Months Day	s Hours M	in. Anr 3		eign Country) DC
		Usual Residence of Decedent					IAPL	. 7 . 1 9 4 3 1	
ar a		10a, State 10b, County MD		own or Location					10d. Inside City Limits
/land -f show	ğ		Bal	timore					1 Yes 2 No
or 28a	Director	10e. Street and Number]	10f. Zip Code			10g. Citizen of What Co	ountry?
0036 within 72 hours after death with the Maryland giene. seer than "matural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	ᄪ	2503 Violet Ave. Apt. 11. Marital Status 12. Was Deceden		12 Was I	21215	nania Osiaia? (Specify Yes or N	USA	eriese Indian Block
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within Medi	Ĕ	12th		Const		on Worl			Industry
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21215-0 21216 w Juld be filed w I Mental Hygic I marked othe	To Be	Samuel David Pounds, S 19a. Informant's Name/Relationship (Type, Print)		19h Mailing A	ddress (Stree		Jenkin	1S mber, City or Town, Sta	to Zin Code\
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygene, n 27 is marked other than numatic event, the Medica	-	Rosa L. Suber/Sister	- 1		3rd St			igton, DC	20011
- d # P		20a. Method of Disposition		ce of Disposition	on (Name of ce		Date	20c. Location - City	
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Baltimo permit. Page Department or Important: injury or ott		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	110.			s of Facility T	tnev's	Funeral	Home, Inc.
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Medical Examiner		Immediate Cause (Final disease a. Multiple Injuries	3						Death
		or condition resulting in death) Due to (or as a cons	equence of):						
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):						
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and and transit	Examiner	events resulting in death) Last	equence of):						
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leath cer e attendii	Sicia	4 Pregnant a	t time of death	5 Other	(Specify)		7-11-1		9
the de	Physicia	Part II. Other significant conditions contributing to deal	h hut not resu	Uting in the und	erlying cause a	riven in Part I	23e Did t	obacco use contribute t	o the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requiring a sher death. a) Director: After this certificate has been sided in by the funeral director, page 2 should be	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	e, farm, street, f	factory, office b	uilding, etc.			Rural Route Number, City	
Compared to the part of the pa								State) f Park Heights Aven	ue , Baltimore , MD
Here and the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
									the cause(s)
03	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (M	
- (L)		(Kaleini)		O.C.I	VI.E.		January 4, 2012	2	
		30. Name and address of person who completed cause of	·	*	more Ct	+ Daltiman	MD 24202		
		Laron Locke MD. Assistant Medical Example 131. Date filed (Month, Day, Year) 31. Registra				ı, paitimore,	IVID 21223		
S Regis	tate	JAN 13 2012	ir s signature	parke	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Maxine **Physician** an 2, 2012 loria /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KecdySville

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 2-7-1940 6047 Smoketown Road Washington Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F Hancack, MD 219-36-4340 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "natural", or itams 23a or 28e-f show other traumatic event, the McDical Examinar must be notified at 1 ☐ Yes 2 XNo Washington Director 101. Zip Code 10g. Citizen of What Country? 10e. Street and Number KOCK. Kd Hanging 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White Baltimore, Maryland 21215-0036 Specify: <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within : th and Mental Hygiene. 7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) residence homemaker 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Keslev Harris Weller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11416 Hanging Rock Rd. Clear Spring, MD 21722 Date of Disposition (Name of Date 20c. Location - City or Town, State Poole s 1 and 2 s of Health ar item 27 ls hendore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1-16-2012 Char Spring, MD 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ŏ permit. Page Department Important: If any injury or once. Blairsvalley Lcm. 22. Name and Address of Facility
Domid Edwin Thompson Funeral Home, Inc
P.O. Box 310 Clear Spring, MD 21722

Approxim 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) adenocarcinoma Metastatic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the a should be detached t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s autopsy perform 2 No 1 Yes Day hte. To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 6 Other (Specify) 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ this I Director: After this id in by the funeral d 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 1 Natural 5 Pending 1 Yes 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 48184 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street Frederick, MD 2170

State Registrar 31. Date filed (Month, Day, Year)

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ESKander, ND 501 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lorna Ruth Pennanen January 14, 2012 4:15p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Autumn Assisted Living Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. Yes 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Year 1923 296-18-0486 88 OH TO **Director** Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 17738 Virginia Avenue 21740 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) sales Red Cross Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental item 27 is marked Page 1 and 2 should be Claude Paul Rowan Ruth Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Fikar - Daughter 17738 Virginia Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Nagerstown Crematory January 16, 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each list. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO Physician/ VASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 the as ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Yes 2 No the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, SCLEROTIC CNADLO 1 Yes 2 No 3 Probably 4 Inknown Completed page 2 should ATRIAL FISRILLA TION PISKASK 24b. Were autopsy findings available 24a. Was an TENSION 2010151 has prior to completion of cause of death? DEMENTIA certificate 2 No Yes 2 Wo 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other (Specify) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No neral Director; / I filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier - wett mo D001801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Parsons 15,2012 1242 Evelvn Jean anvar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Wicomic Salisbur Rehabilitation Nursing Ctr 5. Social Security Number [6. Sex 7. Age (In yrs. last birthday) sbu If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Davs Hours Min. Maryland Director 213-22-6706 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Avenue 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Parson Black. White, etc. Completed by 1 Never Married 2 Married 21215-0036 If Yes, Give 1 Tes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Laird Opa1 Lively Ramzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Parsons, Jr. - Son Clearbrook Blvd., Seaford, Delaware 19973 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-16-2012 Crematory of Delmarva Delmar, Delaware Signature of Foreral Service Licenses 22. Name and Address of Facility Bounds Funeral Home Ε. Main Street. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Thrositero Cardiovarenter Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Duá to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Vear signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 00 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗌 Yeş 2 🗌 No filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) 28 1/16 12 30. Name and address of person who completed cause of death (Item 23a) (Typen Print) Ave. falostay B

Registrar DHMH 17 Rev 7/2009

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324 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 12^{Day} Elisha William Parker, Jr. 2012 1:20 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7074 Forest Grove Road Wicomico Parsonsburg Social Security Number 8. Date of Birth
(Month, Day, Year)
10-14-1922 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days Hours 1 X M 2 - F **Director** 213-16-7440 89 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD 1 Yes 2 X No Wicomico Parsonsburg 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 7074 Forest Grove Road 21849 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married than "natural", or Completed by 1 X Yes 2 No 1942-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced 1945 Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Mechanic Automotive is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elisha William Parker, Sr. Nora 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Parker - Son 7074 Forest Grove Road, Parsonsburg, Maryland 21849 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 1-17-2012 Delmar, Delaware Stephens Cemetery! 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Ligensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party one cause on each line. Immediate Cause (Final disease or condition Onset and Death SUDDEN Physician/ EATH Medical resulting in death) Due to (or as a consequence of): Examiner DISE ASE ARTERY CORBNARY Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last MYOCARDIA that the death certificate be executed NEARCTION Due to (or as a consequence of): Physician/Medical ACEMAKER Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown signed by the atter Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man - r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Prantioner: To the best of my knowledge id 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M) 138647 RUN 01-13-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 11:12 AM Joseph Edgar Robert 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Funeral If Under 1 Year If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 577-36-8748 Director 1 ₺ M 2 🗆 F 81 3/7/1930 Wahsington DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1301 McHenry Ct. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Joseph Robert Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Commercial Real Estate Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph A. Robert Loretta McClellan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1301 McHenry Ct., Barbara H. Robert Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/12/12 State Crem. Millsboro, DE Burbage Funeral Home 22. Name and Address of Facility 108 William St., Berlin, MD 21811 Part 1. Enter the disease or complications that shock, or heartrailure. List only one cause on ea ϵ aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has the funeral director, page 2 s performed3 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 24 No Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) to SI 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ე 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 WAR 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Month Rutlidge Micheline Jan. 5:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Chevy Chase Chevy Chase Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 1 M 2 X F 82 Hours March 4,1929 118-28-5266 Director Michigan Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland Montgomery Chevy Chase 1X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 USA 8700 Jones Bridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian. Black, White, etc. 9 à 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 nan "natural", Medical Exar 1 ☐ Yes 2 X No Specify: White Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+ WS Government the Secretary event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Maurice L.C. Rutlidge traumatic Reine Bosc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or any injur Richard Thompson/Executor 6428 Wishbone Terrace Cabin John, MD 20818 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fulleral Service 22. Name and Address of Facility DeVol Funeral Home MO1315 2222 Wisconsin Ave., N.W. Wash., DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 020NAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform death? certificate l 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 KNo Other 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral at the fun 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in more stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29d. Date signed (Month. Dav. Year) 00057124

State

Registrar

10110 Molecular Dr. #206 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD
31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - State Registrar	State of Marylar	-	irtment of l tificate of L		Mental Hy	giene Reg. No. 2	012	02457
ı	Physicia Medic		Decedent's Name (First, Middle, Last) Beulah Pearl Roby					2. Date of De Januar		20 12	3. Time of Death 4:00A . M
	Examir		4a. Facility Name (if not institution, give stree 204 Kings Crossing (4b. City, Town, o Bel Air	r Location of Deat	n	4c. Cour	nty of Death	l
	Funeral Director	Г	5. Social Security Number 6. Sex 1 \square M	7. Age (In yrs. I	as <i>t birthd</i> ay) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir			olace (State or Foreign
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		y, Town or Loc	ation				1	0d. Inside City Limits 1 ☐ Yes 2 🛂 No
	with the Ma 23a or 28a ist be notii		10e. Street and Number 204 Kings Crossing (10f. Zip Code 21014			10g. Citizen o	of What Cour d Stat	ntry?
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If		ispanic Origin? (Span, Mexican, Puert Specify:			ace - Americ lack, White, ify: Whi	etc.
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "nat i the Medica	Completed	15. Decedent's Educat (Specify only highest grade continuous)		(Give k life. DC	ent's Usual Occup ind of work done o NOT use retired) tary/Co-	during most of wor	king	16b. Kind of	Business In	
land 2	d be filed w dental Hygi irked other tic event, t	To Be	17. Father's Name (First, Middle, Last) George B. Whitehead		50020	54297 65	18. Mother's Nar	me (First, Middle, • Riddle	Maiden Surna		···
, Mary	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, F Sandra Biernazki –da		19b. Mailing	g Address (Street a Meadow T	and Number or Ru ree Driv	ral Route Numbe e White	r, City or Town Hall,	, State, Zip (Maryla	and 21161
imore	Page 1 arment of He tant: If iten		20a. Method of Disposition 1 ⁴ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		Place of Disposemetery, cremaney Val	atory or other place	dns. 1/1	Date 4/2012	20c. Location	-	
Balt	permit Depart Impor any in		21. Signature of Funeral Service Licensee Rosed & Boye	rank						, PA , Mary	land 20705
-1	Physician		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that caused the deatl use on each line. Dementia	h. Do not enter	the mode of dyin	g, such as cardiac	or respiratory ar	rest,	2	Approximate Interval Between Onset and Death YEARS
	Medical Examiner	يــ	resulting in death) Sequentially list conditions, b. =	Due to (or as a consequ	ience of):						
	icate be executed physician and sthe burial-	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last C. Due to (or as a consequence of): d.								
260	cate be e physiciar s the buris	edical									
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-forcial.	Physician/M	in the past 12 months?	f yes, outcome of pregna	2 Fetal death 3 Ectopic pregnancy					Date of delive Month	ery Day Year
ls, P.O.	uires that th n signed by ild be detac	ed by Ph	Part II. Other significant conditions contrib Clostridium diffici				ven in Part I.				ne cause of death?
Record	The law requarte has been page 2 shou	Completed by						24a. Was autop perfo	osv	o. Were autor prior to cor death? 1 \(\sum \text{Yes}	osy findings available mpletion of cause of
Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hosp	tal: 1 Inpatient 2	ER/Outpatient	Othe	ace of Death (Checer:	ok only one)	lence 6 \(\text{O} \)	ther (Specify	
on of	ending Physath. or: After thi	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at	28d. Describe h			
Divisi	oital or Attures after de ral Directo		4 I Hollidae determined	8e. Place of Injury - At ho building, etc. (Specify,)			28f. Location (S City or Tow	n, State)		·
	he Hosp lin 24 ho he Fune ppleted fi	Medical	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Check only one) (Check only one) (Check one)	In the basis of examination	≀ and/or investi	gation, in my opinio	n, death occurred a	at the time, date a	nd place, and c	lue to the cau	use(s) and manner stated.
29b. Signature and title of certifier D42129								29d. Date signed (Month, Day, Year) January 11, 2012			
			30. Name and address of person who comple William D. McConnel	L, M.D. 6301	N. Cal	hrles St	reet, #5	Baltimo	ore, Ma	ryland	21212
	Stat Registra		31. Date filed (Month, Day, Year) JAN 12 2012	62. Registrar's Signat	ure Soci	J.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar State of Maryland / Dep	artment of Health and I	, ,	ne 2012	02458
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Debra Lee Roberts		2. Date of Death Month		3. Time of Death
my O'	Examir		4a. Facility Name (if not institution, give street and number) Meritus Medical Center	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washingto	on
	Funeral Director		5. Social Security Number 213-68-6288 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 X F 53 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. Sept. 25	ar) Country,	
	Maryland 28a-f shov otified at	Funeral Director	10a. State 10b. County 10c. City, Town or Lo Maryland Washington Keedysvil			10d	I. Inside City Limits 1 Yes 2 No
	s 23a or	eral D	10e. Street and Number 3930 Trego Mountain Road	10f. Zip Code 21756	"	. Citizen of What Country JSA	n
9800	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 X Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc Specify: White	
21215-0036	within 72 hor /giene. her than "nat t, the Medica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired) rwriter	ang	b. Kind of Business/Indus	
Maryland	should be filed n and Mental Hy 7 is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) James Clifton Cooper		ne (First, Middle, Maid Viola Rohr	,	
	1 and 2 should be if Health and Men item 27 is marke other traumatic		Wesley Roberts (Husband) 3930	ng Address (Street and Number or Rur Trego Mountain Ro			
Baltimore,	permit. Page 1 a Department of h Important: If ite any injury or ot		20a. Method of Disposition 1 🔀 Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify)	osition (Name of matory or other place) Manor Cemetery 1-2		c. Location - City or Towr arpsburg, Ma	
Ball	permit Depart Import any in			2. Name and Address of Facility Osi 25 S. Conococheag			
	Ph _e sician Medical			er the mode of dying, such as cardiac &ビ <i>S</i> T	or respiratory arrest,	ln:	pproximate Inset and Death
لم	Examiner	e.	Sequentially list conditions, b. Ventrular	Trehy candi	а	M	mute
	ite be executed hysician and the burial-transit	dical Examiner	cause Enter Inderlying	Slare		7	ears
. Box 68760	ath certifica attending p for use as	/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	ay Year
ds, P.O.	requires that the dec been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underspread or productions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contributing to death but not resulting in the underspread of the contributions contri	()		co use contribute to the c	
Division of Vital Records,	Physician: The law rec r this certificate has bee aral director, page 2 sho	Completed	Takayasu's Arteritis	e-dormuchue	24a. Was an autopsy performed	24b. Were autopsy prior to comp death?	letion of cause of
ta	cian: ertific ector,	Be (25. Was case re erred to medical examiner?	26. Place of Death (Chec			
Ę	Physi this c	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of			6 Other (Specify)	
ion o	tending l death. tor: After the funer	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 Yes 2 No	28d. Describe how in	njury occurred	
Divis	oital or At ours after o eral Direc filled in by	al Cert	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, St		oute Number,
	ne Hos in 24 ho ne Fune pletely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of t	tigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause	(s) and manner stated. ed.
	Verith Collection		29b. Signature and title of certifier Authority Applements	29c. License number	29d.	Date signed (Month, Day	(, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F Monica Stallworth, MD 1500 Pennsylva:			- ZO - ZC	12
	Stat Registra	e	31. Date filed (Month, Day Year) 2012 32. Fegistrar's Signature	and wenter hagers	COWILL FID Z		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8^{Day} Physician/ Gary James Ryan 2012 5:46 P M January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Director** 061-20-6027 1 🗶 M 2 🗆 F 83 11/12/1928 New York 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at **Funeral Director** 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a 456 Nolcrest Rd. 21061 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant! If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1951-Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Yes, Give 1953 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
s marked other than "I life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer years Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vincent J. Ryan Sarah E. Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Ryan/ Son 1134 Silverleaf Drive, Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 N Removal from State 4 Donation 5 DOther (Specify) Department o Important: If any injury or Millport Cemetery 1/16/2012 Millport, New York Signatu Feneral Service LL Insee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month Day 1 Yes 2 L g 🗌 Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
Yes 2 \(\subseteq \text{No} \) Be 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Mont JAN 1 2 2012 Registrar

29b. Signature and title

30. Name and addre

egistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 10 BERNARD DENNIS ROGERS 2012 8:46 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 120 RADCLIFF ROAD GRASONVILLE OUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** ocial Security Nur 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 212-42-3758 Min. Hours **Director** 1 **X** M 2 □ F 67 05/14/1944 MARYLAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director QUEEN ANNE'S GRASONVILLE 1 Yes 2 X No 5 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 120 RADCLIFF ROAD 21658 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married þ 1 X Yes If Yes, Give 2 No Maryland 21215-0036 72 hours after 1962 1 Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Specify: WHITE Completed 1965 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) t of Health and Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) MASTER PLUMBER & GAS FITTER PLUMBING 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BERNARD FRANCIS ROGERS DELORES TAYLOR or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY KAPTAIN / SON 5622 EAST STUCKER ROAD, LEXINGTON, IN 47138 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite Date cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 1 Burial 2 X Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 01/13/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Promiciany SWAU HIMM disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Examine Due to (or as a consequence of): burial-tra Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 100 Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death. Director: Af Accident 1 Yes 2 No the Investigation within 24 hours after dea To the Funeral Director completely filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying furse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sia + 19 rutis 30. Nar tw 31. Date filed (Month, Day, 32. Registra s Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Ам Radcliff 9:51 Frances Caro1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 4931 South Upper Ferry Road Eden Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 🗆 M 2 👿 167-34-7930 **Director** Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Wicomico MD Eden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral within 72 hours after death with 21822 USA 4931 South Upper Ferry Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give 5 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Assembly Technician Be 17 Father's Name (First Middle Last) 18 Mother's Name (First, Middle, Maiden Surname) ဂ္ Goodwin Rose Sharkey and 2 should be Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eden, Maryland 21822 3752 South Upper Ferry Road, Matthew Radcliff - Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 Durial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 1-16-2012 Delmar, Delaware Crematory of Delmarva 21. Signature of Puner Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISPEASIZ HRONIC 8135 MONAR disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death the detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 2/1 No ၉ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Ceath 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hc

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR

			State of Maryland / Department of Health and Mo			02462
			Registrar Certificate of Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an		Month	Day Year	
	/Medic		Carolyn E. Whittington 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		10 2012 4c. County of Dea	10:10 ^{a M}
	Examin	er				
	Funeral		247 N. Somerset Ave, Apt B Crisfield 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Somerse	rthplace (State or Foreign country)
	Funeral Director	İ	214-46-2700 1 M M F 64 Yrs. Months Days Hours Min.	(Month, Day 3-13-1		(ountry)
940	2		Usual Residence of Decedent			
	arylar	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	Ba-f	Director	MD Somerset Crisfield			
	be filed within 72 hours after death with the Maryland Hygiene. A they filed then "natural", or iteme 23a or 28a-f ehow do other then "natural", or item 23a or 28a-f ehow event, I' to Madical Examinating the modified at	급	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	239 e 239	Funerai	247 N. Somerset Ave, Apt B 21817		JSA 14. Race - Am	occan ladian
	them them	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Speil Hyes, specify Cuban, Mexican, Puerto Full Hyes, Specify Cuban, Mexican, Puerto Full Hyes,	Rican, etc.)	Black, Wh	
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7	d with giane.	Completed	2 Cosmetologist		Beauty S	alon
2	be file ital Hy od othe	ВеС	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Sumame)	
<u>a</u>	should be ind Mental is marked o umatic eve	2	Wilbert Walston, Sr. Catherin	e 0. E	Forbes	
0	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural)	Route Numbe	er, City or Town, State,	Zip Code) 21817
2	and and and and and and and and and and		Dana Whittington/Daughter 247 N. Somerset Ave	. Apt	B, Crisf	ield, MD
20	of Head of Head of Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other parts)	ate	20c. Location - City of	r Town, State
	permit. Pages Department of Important: If it eny injury or o once.		4 Donation 5 Dotter (Specify) Macadonia Mom Dk 1 21	2012 V	Westover,	MD
<u> </u>	permit. Departi Import eny inj		21. Ignature of Feering Service Licensee	W. Is	sabella S	t.
<u>. </u>	ZO E 2 9		Funeral Home Sal	isbury	y, MD 218	01
•	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		161	Approximate Interval Between Onset and Death C Mum
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			1
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.O. DOX	The law requires that the death certificate are hes been signed by the ettending phys page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)		23d. Date of d Month	elivery Day Year
cords, r	uires that signed t Id be det		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
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ב נ	eician: The law s certificete hes t lirector, page 2 s	mc d mc		autop	rmed? prior to	completion of cause of
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5	nding ith.	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
2	r Atte er dez recto by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or i	Rural Route Number,
2	ppitel o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the	cause(s) and manner	as stated
	To the Hospitel or Attending Physician: within 24 hours alter death To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time,	date and place, and de	ue to the cause(s)
	To To	Σ	29b. Signature and fittle of certifier 29c. License number		29d. Date signed (Mo.	nin, Day, Year)
1	TC		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ASKINS MD -701 Hole Mughe	use	CARSIO	ld m
-) `		31. Date filed (Month, Pay, Year). 32. Registrar's Signature	0	-, 3, 2	18/6
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month Physician/ Reginald Norman Smith anuan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plato Civista a If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months 1 ★ M 2 □ F Hours Director 1951 Georgia 4. 224-76-6333 May Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 XNo Maryland Charles Hughesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 15110 Burnt Store Road Apt. 20637 United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Yes 2 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 hc h and Mental Hygiene. 7 is marked other than "na (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United States Army 4 Aircraft Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Norah B. Brown Jack L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 889 Lake Elsinore, CA 92531 Laury Mattenson/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Burial 2 XCremation 3 - Removal from State 1-16-2012 Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service Licen-22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M01458 St. Mary's Ave. Box 567 La Plata, 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E ter crace, his Cause (Disease or linjury Examine Due to (r as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. OV use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a sequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? Yes 2 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No 1 Yes Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer -13 -2012

BU. Sta

Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 17

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012^{Year} Alberta Agnes Sea1 9, January 7:35 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mariner Health-Bethesda Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) 82 yrs If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Days Hours Min. Months 577-40-7993 Director Jan. Usual Residence of Decedent 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1202 Halesworth Drive 20854 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: SpecifWhite "natural", 3 ™ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Rep. Womens' Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ Joseph John Mazur Elizabeth Custer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Robert Seal/Son 1202 Halesworth Drive, Rockville, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Jan. 12, 2012 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, MD 21. Signature of Funeral Service Licens rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Dent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Physician/ Cardiovascular diseases disease or condition resulting in death) Inknocon Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, boaring to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): th and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months 1 Yes 2 No Month Dav Year 1 Yes 2 Unknown the signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Dyslipidemia, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N 1 Yes 2 No 25. Was case referred to edi Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 12 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A:

Completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Chowde 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 605 Main Street , Laurei ,

State Registrar

NURUL 31. Date filed (Month, Day, Year)

CHULDHURY, MD;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Aug. 15, 1936 If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Maryland 1 □ M 2 🖔 F 75 217-32-7305 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show 1 ☐ Yes 2XX No Directo Washington Williamsport Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be 21795 USA 8511 Dam #4 Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2\(\) No 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2XXNo "natural", or If Yes, Give Year or Dates: Specify Specify 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Home Housewife permit. Pages 1 and 2 should be filed beatment of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burkett Clara Rebecca Richard Herman Boppe ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8511 Dam #4 Road Williamsport, Maryland 21795 Carl W. Socks- Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial St. Paul's Cemetery Jan.20,2012 Clear Spring, Maryland 4 ☐ Donation Other (St 21. Signature of Funeral Privice Osborned Ferrer Fillithome, P.A. 21795 425 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical D e o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Be Completed by Physician/Medical Exami attending physician and for use as the burial-trar been signed by the should be detached certificate has birector, page 2 s this certific Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of);	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yoo 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown
		24a. Was an autopsy performed 1 Tyes 2 No 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death	
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27. Manner of Death Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, ininer: On the basis of examination and/or investigation, in my opinion, death occurred	

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 31. Date filed (Month, Day, Year) JAM 2

29b. Signature and title of certifier

and manner stated.

Mich	ael Da	vid S	chau	ber

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	1- For State Registrar		Certificate	of Death			Reg		112 0240
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Medical Examine		id Schauber Sr		145 0% ±	!#:		nuary 21,	2012 4c. County o	1521 nrs
	4a. Facility Name (if not instituti 10 Village Street #61			Eastor	wn, or Location	in or Death		Talbot	Deam
Funeral	5. Social Security Number		(In yrs, last birthday) If Under 1 Year If Under 24Hrs.			nder 24Hrs. 8, D	ate of Birth	(MM/DD/YYYY)	9. Birthplace (State or
Director	257-94-6345	1 X M 2 F	53	Yrs. Months	Days Hou	urs Min. 1(0-13-1	958	Foreign Country)Kansas
	Usual Residence of Decedent								
y any	10a. State 10b. County		City, Town or L	ocation			·		10d. Inside City Limits
and fshow	MD Tal	bot	Easton						1 X Yes 2 No
the Maryland a or 28a-f sh tiffied at ooce	10e. Street and Number			10f. Zip (I -	. Citizen of Wha	at Country?
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r death with or items 23 r must be 00 Funeral	11. Marital Status 1 Never Married 2	12. Was Decedent Ever Armed Forces?				origin? (Specify ` an, Puerto Rican		14. Race - White,	- American Indian, Black, , etc.
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2. 28 8 8 6 l o	Adam B. Schau 19a, Informant's Name/Relation		19b Ma	ailing Address		hirley A			, State, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 7 nent of Health and Mental Hygeiene. Isot: If item 27 is marked other than or other traumatic eveet, the Medical To Be Comple		ant sister-in-1	1.7		•			-	1D 21654
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Baltimore, I bernit. Pages 1 and Department of Heal Importaot: If item injury or other tra		n 3 Removal from State	Chesane	orotherplace) ake Cre	nation	1-24-2	2012	Ctorrono	sville, MD
nit. P artme oorts	4 Donation 5 Other 3 21. Signature of Funeral Service	e Licensee	2	Center 22. Name and A	ddress of Faci	ility		(V. (III)	
De per juli	JOHN R.	MERCERO D		200 S.	Harris	on St.	Easto	n MD 21	eral Home, P.A. 1601
Physician	23a. Part I. Enter the disease, of failure. List only one caus-		death. Do not en	ter the mode of	dying, such as	s cardiac or respi	iratory arres	t, shock, or hea	rt Approximate Interval Between Onset and
Medical. Examiner	Immediate Cause (Final diseas	e a Citalopram		ohol In	oxicat	ion			Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the flueral director, page 2 should be deached for use as the bunial - transit edical Certification: To Be Completed by Physician/Medical Ex	X UNPENDED	X AMENDED1,23a	,27,28a-	f,per m	e,g924	2-6-12	sm		
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Division of Vital Records, to or Atteoding Physiciae: The law requirers after death. a) Director: After this certificate has been sited in by the funeral director; page 2 should berification: To Be Completed				26		th (Check only or			
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Division of Vital Rec aptal or Atteoding Physiciae: The bours after death. orral Director: After this certificate filled in by the funeral director, page Certification: To Be Con	3 Suicide 6 X Cou	ald not be	Found a				or Town, Star		lage St. #61
Hospital 24 hours a Fuocral riely filled		Physician: To the best of my kno	owledge, death o	occurred at the t		place, and due to	o the cause(s) and manner	
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H S H S	29b. Signature and title of certif				icense numbe	er			d (Month, Day, Year)
	N-20-				O.C.M.E.			January 22,	2012
		n who completed cause of death		000 M/ Ball:	more Stree	et, Baltimore,	MD 212	23	
State	Donna M. Vincenti, N a 31. Date filed (Month, Day, Year			OU VV. Daili	noie oliee		1VIU 2 12		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physician	_	1. Decedent's Name (First, Middle, Last) Raymond Lee Sears						2. Date of Deat January		2 ^{Year}	3. Time of 0	Death A M	
Medica Examine	taminer 4a. Facility Name (if not institution, give street and number) 1276 Log Canoe Court					4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arund			
Funeral Director		5. Social Security Number 216-40-1286 Usual Residence of Decedent	7. Age (In yrs. last bir 69	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs, Min.	8. Date of Birth (Month, Day, 8/6/194	Year)	Count	lace (State or ry) yland	Foreign	
th the Maryland 3a or 28a-f show t be notified at	Director	10a. State 10b. County 10c. City, Tow Maryland Anne Arundel			ation	moli	ls	11	10d. Inside City Limits 1 ☐ Yes 2 ※ No				
	al Dir	10e. Street and Number			10f. Zip Code 21403				What Coun	hat Country?			
eath wif	Funeral	1276 Log Canoe Court 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			as Decedent of His	in? (Spe							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ò	1 Never Married 2 Married 1 X Yes	Never Married 2 X Married 1 XYes 2 No			If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☐ X No Specify:				Black, White, etc. Specify: White			
	Completed	(Specify only highest grade completed) (Give kill Elementary/Secondary (0-12) College (1-4 or 5+)			ent's Usual Occupa nd of work done d NOT use retired)	uring most		ng	16b. Kind of Business/Industry				
iled with I Hygier other t vent, th	Be	17. Father's Name (First, Middle, Last)	Con	nputer An 	-		NSA e (First, Middle, Maiden Surname)						
uld be f I Menta narked natic ev	잍	Raymond Bernise Sear			Imelda Elaine Wonneman								
d 2 sho laith and n 27 is i							t and Number or Rural Route Number, City or Town, State, Zip Code) noe Court, Annapolis, MD 21403						
age 1 an ent of He it: If iten y or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State cemete	ery, crema	ition (Name of atory or other place			Date 3 1 / 1 / 1	20c. Location				
permit. P Departme Importar any injur		4 Donation 5 Other (Specify) Hillcrest Memorial Gardens 1/14/12 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401											
00540		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property filled in by the funeral director, page 2 should be detached for use as the burial-transit and property filled in by the funeral director, page 2 should be detached for use as the burial-transit and property filled in by the funeral director, page 2 should be detached for use as the burial-transit.		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a donsequence of):				infarction				^	Onset and D	eath	
	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Under Vabuua Vabuua Under Vabuua								years			
	Physician/Medical	in the past 12 months?	tcome of pregnancy Birth 2 Fetal dea gnant at time of death nown		Ectopic pregnanc Other (specify)	у				ate of delive		éar	
uires that the signed by the signed by the detail	by	Part II. Other significant conditions contributing to death but not resulting in the underlying ca			derlying cause giv	en in Part I	l. 	23e. Did to	bacco use con es 2 No		ne cause of de bably 4 🗌 t		
nding Physician: The law requth. After this certificate has bee e funeral director, page 2 shot	Completed							24a. Was a autop perfor	sy	Were auto prior to co death? 1 \(\subseteq \text{Yes}	osy findings a mpletion of ca 2 \(\textstyle \text{No}\)	vailable ause of	
	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify))		
	cate:	27. Manner of Déath Actural 5 Pending (Mc) Accident Investigation	Time of injury				28d. Describe how injury occurred						
al or Atter s after dea I Director ed in by the	Certificate:	3 Suicide 6 Could not be	e of Injury - At home, f ling, etc. (Specify)	- At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
n 24 hours le Funera	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To th within comp	~	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/9/12											
10		2002 MILLICAL VIVILLA	ise of death (Item 23a)) (Type, Pr	Finnana	. CIL	MD	Rober 24	t s. y	den			
Stat Registra		31. Date filed (Month, Day, Year) JAN 1 2 2012 32.	Registrar's Signature	b. A	back								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 09:50PM 2013 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Ame MD LINDE trimapolis If Under 24 Hrs. If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 🕅 M 2 🗆 F Months Hours Min WASHINGTON, 70 Yrs. Director 578-54-9247 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No QUEEN ANNE'S MD STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 122 BALTIMORE DRIVE 21666 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 1 Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Marting 1000. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ PROPERTY MANAGER **GROCERY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ JAMES E. SOUTHALL GENE ELIZABETH GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 BALTIMORE DRIVE, STEVENSVILLE, MD 21666 JUDITH H. COSTELLO/COMPANION 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEARE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/2012 STEVENSVILLE, MD Signature of Funeral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Emand The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events alouse and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Dav 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached to Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes ျ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1.X Natural 5 Pending injury work? 2 | No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day

park.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

13

32. Registrar's Signature

Parkway

Annapolis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Physician/ 2012 9:50 COLE BRYANT SANDEFER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** QUEEN ANNE'S STEVENSVILLE 203 OAKWOOD LANE 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Davs Hours 08/17/2010 Months VIRGINIA **Director** 692-16-2511 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1 Tyes 2 X No STEVENSVILLE **OUEEN ANNE'S** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 203 OAKWOOD LANE 21666 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) N/A N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ALAYNA KAY SCHULTE JESSE LYNN SANDEFER 1 and 2 should bot Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 203 OAKWOOD LANE, STEVENSVILLE, MD 21666 JESSE SANDEFER / FATHER or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State WOODLAWN CEMETERY 01/21/2012 COLUMBIA FALLS, MT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD, & NEWNAM FUNERAL HOME, P.A. CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani Heural Medical resulting in death) ue to (or as a consequence of) Examiner alianant Section tistly list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician Physician/Medical law requires that the death certificate be P.O. Box 68760 the for use as attending IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No the Hospital or Attending Physician; The I hin 24 hours after death. the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1.X Natural 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certifier MO D62891 1/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

SHANA S. JACOBS, MD

JAN 17

31. Date filed (Month, Day, Year)

park-

32. Registrar's Signature

111 MICHIGAN AVE. NW, WASHINGTON, DC 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ 10 PM 20/2 Vernon De'Grofft Stewart Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 omico 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Mir 138-28-2139 76 Director 1 XM 2 □ F June 21, 1935 Pennsylvania 28a-f show 10b. County at 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🔀 No Maryland Somerset Eden 0 et and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 14560 Sandy Lane 21822 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Operator DuPont Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever 2 Joseph Stewart Elizabeth Bonin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Madeline Scheeper (Sister) P.O. Box 217 - Clayton, NJ 08312 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Buriai 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 C Other (Specify) 1/17/2012 Eglington Cemetery Clarksboro, NJ 21. Signature of Euneral Service II speed Annual Servi 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IE FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter d be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2/ No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy Yes Hospital or Attending Physician: 724 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 28 No Other: Other (Specify) HOSPICA မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

05

29d. Date signed (Month.

Dav. Year)

80

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thompson 17:37 PM Medical CONST 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death me dical Center Baltmore Baltimore City 5. Social Security Number 8. Date of Birth (Month, Day, Sept. 2 . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Min Days 212-50-9377 Director 64 Maryland 1947 Usual Residence of Decedent show 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Virginia Avenue 21740 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) First Data life. DO NOT use retired) College (1-4 or 5+) customer service Merchant Services Be 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas William Thompson Bessie Mae Flurie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Thompson - wife 1309 Virginia Avenue, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/12 Hagerstown Crematory Hagerstown, Maryland Tuneral Service Lie MINNICH FUNERAL HOME 22. Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5+490 Wel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 4095 Alcohol a buse Sequentially list conditions, Examine Disc to for 85 a nonegouering on cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy death? Scizures 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 🔁 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and a 3 Certifying Nurse Practioner: To the best of my structure. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Baltimore Md. Center

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Pa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ oseon Iravers 3:10a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES CHARLES COUNTY NURSING & REHABILITIATION CENTER LA PLATA Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 217-30-0653
Usual Residence of Decedent Director 1 **X** M 2 □ F 87 MARYLAND JANUARY 25, 1924 r 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 X No MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country ms 23a or must be r Funeral 7630 BENSVILLE ROAD 20603 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon Armed Forces?

1 ☐ Yes 2 No an "natural", or iter Medical Examiner Black, White, etc. 1 X Never Married 2 Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry | Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) the 8TH GRADE FARMER FARMING th and Mental Hygier 27 is marked other t traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Page 1 and 2 should be nent of Health and Menta GEORGE TRAVERS BERTHA FENWICK TRAVERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is y or other tra 711 WICOMICO STREET, LA PLATA, MARYLAND SHIRLEY MC KAY / NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or once. ST. JOSEPH'S CHURCH CEM. JAN. 20, 2012 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses THORNTON FUNERAL HOME, P.A.

1. Signature of Funeral Service Licensee

THORNTON FUNERAL HOME, P.A.

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THORNTON FUNERAL HOME, P.A.

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THORNTON JOHNSON MOO583

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1. Signature of Funeral Service Licensee

THORNTON FUNERAL HOME

THORNTON FUNERAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e cancer Immediate Cause (Final M Physician/ eta disease or condition Medical resulting in death) Due to (or as a con **Examiner** Lena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ension Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 XN 25. Was case referred to medical Vita 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) _ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral of 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury To the Hospital or Attending 5 Pending 1 Natural work?
1 Yes 2 No Division 3:10 GA M Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 71199 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) whon Blvd, Switz, Glen Burnie, MO, 21061 31. Date filed (Month JAN 18 20 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 10g per fh, g924,02/02/2012dhb

Certificate of Death

Red. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Physician/ PM 02 natid 0. 2012 01 Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital 7. Age (In yrs. last birthday) 1+1 Himore Baltimore 8. Date of Birth 9. Birthplace (State or Foreign If Unde Funeral Months Min (Month, Day, Year) Country 112 36 3580 Director 1 □ M 2**XX**F 71 4-1-40 Schwatz Austria Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits at 10c. City. Town or Location Director notified PA LANCASTER LANCASTER. PA 1 🗌 Yes 2 🗌 No 10f. Zip Code 10e. Street and Numbe ō 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be r Funeral Austria 207 Bank Barn Lane 17602 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian Was Deceuent ____ Armed Forces? 1 ☐ Yes 2 ▼XNo Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XXVo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) plus Homemaker Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Department of Health and Ment.
Important: If item 27 is marked
any injury or other transment Ernst Ortwein Martha Vogl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Bank Barn Lane Lancaster, PA JON TRYON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 1-10-2012 Leola, PA 17540 Evans Crematorium 4 Donation 5 Other (Specify) 22. Name and Address of Facility 528 W. Orange St. Lancaster, PA17603 The Groffs Family Funeral & Cremation Serv. any in 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner noraco abdominal angurysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 for use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Year Month Day hed 9 Unknown 9 Unknown be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ▼ Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 2 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28d. Describe how injury occurred 1 Matural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

600 N. Wolfe St Baltimore Maryland

2012

January 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 12, 201^{rear} Genevieve Louise Voorhees 9:56 aMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 8. Date of Birth
(Month, Day, Year)
Aug. 21, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 1 🗆 M 2 🕱 F Hours Min. Director 162-07-8226 Yrs 99 Ĭ 912 Aug. Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 406 Neale Court 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or ģ 1 Never Married 2 Married ☐ Yes 2 😿 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Midowed 4 Divorced Specify: Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental | Important; If item 27 is marked o Charles Edward Sleeman Minnie Mae Sleeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Kay V. Smith/Daughter 406 Neale Court, Silver Spring, MD 20901 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or Jan. 12, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 2012 21. Signature of Funeral Service Licensee

Francis J. Collins Funeral
500 University Blvd. W., Si

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Francis Address of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Onset and Death arteriosclerone cardiovascular disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2-N of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 - 100 Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 24 hours after death. Funeral Director; A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the f within 24 hours after de.

To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/12/2012, 55410

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) no

Yeveeny

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ January 8 2012 2012 4:17 Рм Joseph L. Violette Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8 Date of Right 9. Birthplace (State or Foreign Days 1 X M 2 🗆 F Months Hours **Director** 131-28-9077 693071937 MASSINE 74 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3098 Sussex Place 21140 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien, is marked other th Nabisco Sales Executive Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leith Violette Madeline Lawlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1273 Walnut Street, Newton, MA 02461 ge 1 and 2 sl it of Health a Terry Violette - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be nding phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 4 Pregnant at time of death 9 Unknown Day 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 70 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 10 Other: ပ 1 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

30. Name and add

31. Date filed (Mo.

JAN 12 2012

Box 68760

P.O.

Division of Vital

ess of passon who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jan 14. Lee Thomas Wilburn, Sr. 201 2:10 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Health & Rehab Fort Washington Prince George's Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 🖵 M 2 🗆 F Days Hours Min. Director Country) 253 58 7550 Oct 10. Georgia 1939 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 99, ~ 00, 6, 6, 2, ... 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sh notified a Maryland Prince George's 1 ☐ Yes 2 ₽ No Fort Washington 10e. Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 13448 Buchanan Drive 20744 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner was becedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No
If Yes, Give
Year or Dates. 1962–1966 Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify **Black** the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police 12 Department of Defense other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mose Wilburn Leona Calhoun permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian G. Wilburn (Wife) 13448 Buchanan Drive, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ò injury 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1/26/2012 | Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses žu Ferry Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if on the list conditions, if one cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day Pregnant at time of death 2 No detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Sacral Decubitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? Feeding Dysfunction 24a. Was an has autopsy performed? Yes 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🏋 No Hospital မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No I Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Cify or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti 29d. Date signed (Month. Day, Year) 042955 2012 30. Name and address of p of death (Item 23a) (Type, Print) M.D2021 Livingston Road, Fort Washington, MD 20744 Edger Potter 31. Date filed (Month, Day, Year) Registrar's Signatur 32 State JAN 18

Registrar

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AMENDJWTFM23/26R2FH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Jo WEIRICH 2012 January 16, 7:50 p. M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 19615 Cool Hollow Road Hagerstown 291249011/5/895 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Dec. 15, 1946 38 6750 65 Mary land **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 1 Yes 2 No Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 19615 Cool Hollow Road 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates white 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 school teacher elementary education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Walter Joe Nye Elizabeth Louise Angle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Ned C. Weirich - husband 19615 Cool Hollow Rd., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1/17/2012 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12月11日かれ Immediate Cause (Final Physicanti DNe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner LEIRODBRAMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examin attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYCRNTENTIAN GRANTEN GRANTENIA 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\overline{D}\) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Mann of Death funeral 28b. Time of Certificate: 28c. Injury at within 24 hours after death. To the Funeral Director: After 1 Natural injury 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. **Tpleted** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 1020 My <u>පයුබුව</u>| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12931 md. 217/2 JW-5 Oak Hier ave. 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Estelle Palma Wilfson January 07, 2012 8:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare Severna Park Anne Arundel 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Director 216-16- 1282 1 🗆 M 2 🔀 F Maryland April 30,1924 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Genesis Way 21146 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 and 2 should be filed within 72 hours afte Health and Mental Hygiene. em 27 is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White Completed 3 Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse HealthCare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fischer Dolores Baumgartner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Catherine Barnes-Smith/Sister 606 Pin Oak Road Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 2<u>012</u> Page 1 permit. Page 1: 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Important: Metro Crematory, INC. Baltimore, MD Signature of Funeral Septice Lic)22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 29a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Fibrilation Atrial Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exam burial-transi Cause (Disease or injury that initiated events congestive Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Dementi that the death certificate be Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No q 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 N the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ ★ n Other: 읻 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practifiener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

id title of certifier

29c. License number

29d. Date signed (Month, Day, Month) 29b. Signature and title of certifier

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State Registrar cal Weteranshin

NOGO STIVE.

milesville, mo. 21108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 13 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH C925 3/16/2012 JH State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 15, 2012 5:00AM PAUL IVAN YORKMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 5. Social Security Number 8. Date of Birth (Month, Day, Year, DEC 21, 1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Hours Director 81 220-24-2133 1930 MARYT AND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🔀 Yes 2 🗌 No HARFORD MARYLAND ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 MEEKS DRIVE 21001 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Completed by 2 🗌 No 1 ☐ Yes 2 X No Specify. Specify: BLACK Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **PROFESSOR** UNIVERSITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLIFTON YORKMAN, SR ELLA TROTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALLEN A. YORKMAN / SON 14 N. SHERMAN DRIVE, BEAR, DELAWARE 19701 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date UNK 1 X Burial 2 Cremation 3 Removal from State 2/15/2012 ARLINGTON NATIONAL ARLINGTON, VIRGINIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE P.A. ~ Coste GRACE 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Lung Directo disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year led by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Pilmenery 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical Lecritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

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Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O.

or Attending Physician: The law

Hospital

Registrar

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29b. Signat

only one)

3 [

31. Date filed (Month, Day, Year)

d title of certifier

JAN 18 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

110054439

29d. Date signed (Month, Day, Year) January 15, 2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

INCENTA GIMINARO, DE DE12 South Toligute Road, #111 Bel Air, MD DIOIS

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth B. Ambrose Month O9: ISPM 2012 CUNUCLY 4 Medical 4c. County of Death/A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death

Baltimore Sinai Hospital of Balhmore 9. Birthplace (State of Foreign Social Security Numbe If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth 7. Age (In vrs. last birthdav) **Funeral** 1 M 2 F 98 (Monyuffat, Y1913 Country) 212-10-4191 Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director **Baltimore Baltimore** MD 1 Yes 2 No 10g. Citizen of What Country? Ambrose, 10e. Street and Number ō 10f. Zip Code ral", or items 23a or Examiner must be Funeral 21207 2121 Windsor Garden Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify "natural", 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Homemaker (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Lavonia Johnson 2 Charles Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 4408 Old Court Road Pikesville, MD 21208 Department of Health a Important: If item 27 is any injury or other trains Barbara Brice 20a. Method of Disposition

1 M Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cernetery & 20c. Location - City or Town, State Feb 03, 2012 Brooklyn Park, Md. 4 Donation 5 Other (Specify) 22. Name and Address of East Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final *nestentions/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of). Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' 1 ☐ Yes 2 ☐ No 1 Yes 2. No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director; After the filled in by the funera 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Carrie M. Anderson Jan 26, 2012 5:00a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** N/A Joseph Richey Hospice, Inc. 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Min nth, Day, Year) **Jan 27, 1930** 217-26-5370 1 🗆 M 2 🕽 F 81 MD Director Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits notified at 10c. City. Town or Location Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code ģ 10g. Citizen of What Country? traumatic event, the Medical Examiner must be Funeral items 23a 325 Mt. Holly Street 21229 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Own Home** Homemaker 12 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elsie Chatman George Chatman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Y. Maddox 2311 Fallsgable Lane, Baltimore, MD 21209 Department of Health Important: If item 27 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Feb 09, 2012 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) **Garrison Forest Veterans** permit. 21. Signature puneral Service Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition YEARS Medical resulting in death) Examiner Sequentially list conditions for the cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 Carrie 23c. If yes, outcome of pregnancy
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Registrar

State

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Anderson

2012

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		1. Decedent's Name (First, Middle, Last) 2. D.						3. Time of Death	
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	Examir	er	4a. Facility Name (if not institution, give street and MERCY MEDICAL CENT	<i>'</i>	4b. City, Town, or Location of Deat	h	4c. County of Deat	h	
	Funeral	_	5. Social Security Number 6. Sex	7. Age (In vrs. last birthday)	BALTIMORE If Under 1 Year If Under 24 Hrs	8. Date of Birtl	Birth 9. Birthplace (State or Foreig		
	Director		214-26-6373 1 M 2	82 Yrs.	Months Days Hours Min.	July 18	, 1929 Con	untry)unk	
	and show	tor	10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits	
	Mary 28a-f notifie	Director	MD Baltimore					1 ☐ Yes 2 🔀 No	
	s 23a or	Funeral L	10e. Street and Number 940 S. Lakewood Ave	nue	10f. Zip Code 21224		10g. Citizen of What Co USA	untry?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 If Ye	Yes 2 ☐ No s, Give 1 or Dates.	Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	vithin 72 hor iene. r than "nat the Medica	To Be Completed		leted) (Give ki	ent's Usual Occupation UNK nd of work done during most of wo NOT use retired)	rking	16b. Kind of Business Industry UNK		
/land	d be filed w Vlental Hyg arked othe		17. Father's Name (First, Middle, Last) unk		18. Mother's Na	me (First, Middle, I	Maiden Surname) unk		
, Mar	and 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (Type, Print Mercy Medical Cente	r 30°	Address (Street and Number or Rull S. Paul St; Ba	lral Route Number, 1timore,	City or Town, State, Zip MD 21202	Code)	
imore	. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify) in	state	atory or other place)	Date	20c. Location - City or	Town, State	
Bai	permil Depar Impor any in		21. Signature of Fune Service License Ala		Name and Address of Facility St 655 W. Baltimore	St; Bal	timore, MD	21201	
	Pnyuician Medical Examiner	iner	Sequentially list conditions, b. ——	that caused the death. Do not enter on each line. RHEJMOHIA Let to (or as a consequence of): HCALCERATED Let 10 (or as a consequence of):	RIUMT NUVINA		-RHIA	Approximate Interval Between Onset and Death IO DAY	
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or iinjury that initiated events c	ue to (or as a consequence of):					
Box 68760	requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year	
ds, P.C	luires that t in signed b uld be deta	by	Part II. Other significant conditions contributing	bacco use contribute to ${}^{\prime}\!$					
Division of Vital Records, P.O.	The law rec	Completed		med? prior to death?	opsy findings available completion of cause of				
ā	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:		26. Place of Death (Che				
of Vi	nding Physician: 1 tth. : After this certifics : funeral director, p	ate: To	27. Manner of Death 1 Natural 5 □ Pending 28a.	1 ☑ Inpatient 2 ☐ ER/Outpatient Date of injury (Month, Day, Year) 28b. Time of injury	3 \[\text{DOA} \] 4 \[\text{Nursing F} \] 28c. Injury at work? M	lome 5 Residence 28d. Describe ho	fy)		
Divisio	spital or Attend nours after death neral Director: A I filled in by the f	Certificate:		Place of Injury - At home, farm, stree ouilding, etc. (Specify)		28f. Location (St City or Town	(Street and Number or Rural Route Number, wm, State)		
_	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To 2 Medical Examiner: On the conly one) 3 Certifying Nurse Practice	d place, and due to the c	ause(s) and manner stated.				
	Note to the contract of the co		29b. Signature and title of certifier Phil MD		29c. License number D 64307	2	29d. Date signed (Month, Day, Year)		
			30. Name and address of person who completed	cause of death (Item 23a) (Type, Pri	PL. BALTINORE	MD	21202		
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 1 2012	345 St. Pavl 32. Registrar's Signature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Januar :00 PM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** -orest Hooper 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours **Director** 1 M 2 🔽 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Nes 2 No 10e. Street and Number 0 10g. Citizen of What Country? Funeral 23a 21085 errapin or items . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3100 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname, ပ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *lerr* 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a conse quence of) cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 6870 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes Yes filled in by the funeral director, To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Inpatient 2 I ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 2300 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10.30AM Emma D. Austin anuary 30 2002 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/20/1917 9. Birthplace (State or Foreign Country)
WV Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Min. 1 □ M 2 🛛 F 94 Director 236-26-7791 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2 No MD Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 305 College Parkway 21012 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No White Specify. If Yes, Give Year or Dates: ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Librarian / Organist Library 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William O. Dunbar Elizabeth Henry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Austin / Son 2067 Warren Road, Lakewood, Ohio 44107 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 1/31/2012 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as I consequence of): - GreTu /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or arrhylog Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 2. No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4- Uursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m.) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NE VEKERANS 8601 MAH 31. Date filed (Month, Day, Year)

ORIGINAL

Registrar

State

DHMH 17 Rev 1/2001

12-00831 William Boone Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 02485

	1- For State Certificate of Registrar		Reg. No.
Physician/ cal Examine	1. Decedent's Name (First, Middle, Last) William — Mich	ael Boone Jr. 2. Date of Dea Month January 2	Day Year 10551
	4a. Facility Name (if not institution, give street and number) St. Agnes Hospital	b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220-84-7645 1 M 2 F 45 Yrs.	If Under 1 Year If Under 24Hrs. 8. Date of B Months Days Hours Min. 10/21	irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY
nd show any ice.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltim		10d. Inside City Limits 1 Yes 2 No
t the Maryland Sa or 28a-f show otified at once.	1914 Chelsea Road	10f. Zip Code 21216	10g. Citizen of What Country? USA
fter death with the properties 23a ser must be noting by Funeral [Decedent of Hispanic Origin? (Specify Yes or Nis, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:	o- 14. Race - American Indian, Black, White, etc. Specify: Black
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Years	s Usual Occupation (Give kind of work done st of working life. DO NOT use retired)	Ship Yard
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medical To Be Compile	a William NI. Boone	18.Mother's Name (First, Middle,	onard
ore, MD 21 s 1 and 2 should of Health and Me If iten 27 is ma ner traumatic ev	Ivonne Leonard (Nother) 19141	Address (Street and Number of Rural Route Number of Communication (Name of cemetery, Date	mber, City or Town, State, Zip Code) + Marce, MD 21216 1 20c. Location - City or Town, State
Pages l	1 Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other Specify:	1 place) 2-4-12	Windsor Mill, MD
	21. Signature of Juneral Service Lidensee 22. Vi 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	St Ballo Nat' Pil	Neral Services (2 (212-79) rest, shock, or heart Approximate Interval
Physician Wedical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
196	Sequentially list conditions, b		
8760, ificate be executed ig physician and sthe burial - transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		
0, be executed sician and burial - transit	UNPENDED AMENDED 1,23a,27,28a-f,	per me,g924 2-15-12 sm	
eath cert attendir for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fett 4 Pregnant at time of death 5 Oth	al death 3 Ectopic pregnancy er (Specify)	23d. Date of delivery Month Day Year
P.O. E res that the d signed by the be detached d by Phy	à		obacco use contribute to the cause of death? is 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. ria or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach entification: To Be Completed by P			
tal Recident The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check only one)	
Physic er this aral dire	1 Yes 2 No Inpatient 2 ER/Outpatient		Residence 6 Other: Scene how injury occurred
tion of Ntrading Phydeath. ttor: After tl y the funeral	1 Natural 5 Pending (Month, Day, Yeer) 2 Accident Investigation (Month, Day, Yeer) fd 1-28-12 fd 10:09	am 1 Yes 2 X No unknown	1
Division o oppital or Attending hours after death. Inertal Director: After y filled in by the fune Certification:	3 Suicide 6 X Could not be determined (Specify) found at hor	me Baltim	(Street and Number or Rural Route Number, City State) 1914 Chelsea Rd.
To the Hos within 24 h To the Fun completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		
F 3 F 5	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 29, 2012
	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. B	altimore Street, Baltimore, MD 21223	
State			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per verb., g924,02/01/2012dbb Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Januari Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death land Greneral x timoro If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Director 1 🛂 M 2 🗆 F and 28a-f show 10a. State 10b. County 10c. City, Town or Location Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director ms 23a or 28a-f s must be notified 1 Pes 2 No MOTE 10f. Zip Code 10g. Citizen of What Country? tems 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 13 ack 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth Date 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory ar other place) 2017 21. Signs of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 6CAS disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death page 2 should be detached 1 Yes 2 L 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 X ER/Outpatient 3 DOA 4 ☐ Nursing Home 3 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date sighed (Month. Day, Year) 12 31 30. Name and address of berson completed cause of death (ttern 23a) (Type, Print) 5

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 1

back

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 6:33 PM Month raxton January 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NIA Sinai Hospital Baltimore of If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) 1 3M 2 F **Director** 62 Yrs 1949 MD 11 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland must be notified at Funeral Director alt mor 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 2/2/ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, injury or other traumatic event, the Medical Examiner rmed Forces? Black, White, etc. δ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Black Specify: Army 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) led ica rarmac Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic ever မ William Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) enegale. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spenty) cemetery, crematory or other place) salt more 2012 of Funeral Service 22. Name and Address of Facility saltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Fibr: 11ation Ventricular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, D5906Z 25 20/Z M. D. M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Baltimore 21215 2401 J. M.A

State

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31. Date filed (Month

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1 _ State							Maryland / Department of Health and Men				1ental Hy	2012 021.88			
	Registrar 1. Procedent's Name (First, Middle, Last)					Certificate of Death				2. Date of D	Reg. N eath		16	3. Time of Death	
ı.		Physician/ 32(0)						idger			Surva	KY =	36 à	Year 2012	05:37 PM
	Examin	J	the Joh		us Hosp	rtal		4b. City, Town, of Baltin	uorc	Cit	4	1 40	c. County		
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	land f show d at	tor	10a. State	10b. County			, Town or Loc	ation							10d. Inside City Limits
	e Mary r 28a-i notifie	Director	MD 10e. Street and Nur	Howard		Lauı	rel	10f. Zip Code				10- 0	Citizen of V	What Cau	1 Yes 2X No
	with th	Funeral		ens Post Co	ourt							USA	ALIZEIT OT V	viiai oou	nu y :
36	after death	Completed by	11. Marital Status 1 Never Marr 3 Widowed	ied 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	_		Vas Decedent of P Yes, specify Cub)-		k, White,	can Indian, etc.
2-00	hours hatura dical E			16a. Decedent's Usual Occupation (Give kind of work done during most of working						16b. Kind of Business/Industry					
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Elementary/Seco		College (1-4 or	5+) Iife. DO NOT use retired) Student					Education				
Maryland		To Be	William S	First, Middle, Last) Stone Bridg	er				arda	ame (First, Middle, Maiden Sumame) a Maria Carrasco—Daroch					
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	neral Service Licensee	Off	MO125		Name and Addr							784 MD 21029
23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition						d the death e.	. Do not ente	r the mode of dyi	ng, such as	cardiac o	or respiratory a		11 KSV		Approximate Interval Between Onset and Death
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	e executed bian and urial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate rlying injury s c.	Due to (or as	a consequ	ence of):	ease							
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici for the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	I death 3	Ectopic pregnar Other (specify)	псу				23d. Da Mo	te of deliv	very Day Year
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Vital	nysician: The nis certificate i director, pag	Be	25. Was case referr examiner?	£ Ho	spital: 🔥			Ott	Place of Dea						
of V	y Physical this ceral dil	e: To	1 Yes 2	NO	1X Inpat 28a. Date of inju	ıry	ER/Outpatien 28b. Time of	28c. Inju	ry at	lursing Ho	ome 5 Res 28d. Describe				5/)
lon	Attending For death. ector: After by the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not be	(Month, Da	iy, Year)	injury work? M 1 Yes 2 No								
Division	Hospital or Attendii 24 hours after death. Funeral Director: A' etely filled in by the fi		4 Homicide	determined	28e. Place of Inj building, et			et, factory, office			28f. Location City or To			er or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	(Check 2	Certifying Physici Medical Examine Certifying Nurse I	: On the basis of e	examination ne best of m	and/or invest	igation, in my opin death occurred at	ion, death of the time, da	ccurred a	t the time, date	and place the caus	ce, and due se(s) and n	e to the ca	ause(s) and manner state stated.
	To the To the commendation		29b. Signature and	title of certifier				29c. Licens	se number			29d. D	ate signed	(Month,	Day, Year) 6 2012 Canal 2457
			30. Name and addr	ess of person who com	pleted cause of c	death (Item	23a) (Type, P	rint)	500	0		مد ا	1000	y 2	. 1
3v	/		Siddl	narth Sri	rutara	60	onlon	th Wol	ee S	+ B	Atim	one	Me.	nyb	and 2007
	Sta	te	31. Date filed (Mon	h, Day, Year)	32. Registr	ar's Signati	ure	,						V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 23, 2012 Ruth E. Bradley 5:58 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Marley Neck Health & Rehab Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs 6 Sex Age (In yrs. last birthday 8. Date of Birth **Funeral** Days Hours Months 1 M 2 X F 93 Month 128 / 1918 215 07 5644 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Glen Burnie Marvland Anne Arundel 1 Yes 2 X No 10g. Citizen of What Country? Funeral U.S. 7575 E. Howard Road 21061 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give White "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Second 12th conday (0-12) College (1-4 or 5+) Homemaker Own Home Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked or permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve Clarence W. Bathgate Sr. Mary A. Drager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McLeskey /Granddaughter 205 Old English Oak Court Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🕱 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/27/2012 Cedar Hill Cemetery Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, Baltimore, Maryland 21225 4001 Ritchie Highway implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part 1. Enter the disease Approximate shock, or heart failure. List o Interval Between Onset and Death Immediate Cause (Final DEMSONO Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions, Examine tary, leading to in medicause. Enter Underlying Cause (Disease or linjury Que to for as a nonsectionne of burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? P Day Year Month 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 🛣 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?

1 \(\sum \) Yes 2 \(\sum \) No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending work 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year) りらろそひら 01/201 2012 wax po dr person who completed cause of death (Item 23a) (Type, Print) 101 Bur

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ January 2012 1:50 Ам Lois May Butler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min Jan 30, 1945 Pennsylvania Director 175-36-2230 1 🗆 M 2 🗓 F 66 show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Ellicott City Howard MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21042 USA 11150 Resort Valley Rd; #305 if Health and Mental Hyglene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after Specify: white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) employment specialist Med Assurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Michner William Bertolet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12900 Old Frederick Rd; Sykesville, MD 21784 Scott Butler - son 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Important: If ite any injury or oth 20c. Location - City or Town, State Date Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Konald Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ 10019 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has I autopsy 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c License number DO060634

Registrar

DHMH 17 Rev 06-2011

State

COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH

31. Date filed (Month, Day, Year)

336

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 4:20 A M Beulah January Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edenwald Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last hirthday) 8. Date of Birth 1 □ M 2 🗓 F July 2, 1916 Mary Land 215-01-2744 95 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21286 800 Southerly Road #1014 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than "hatural", or Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Grill Myrtle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Southerly Road, #1014 Towson, Maryland Henry M. Brown Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 2-1-2012 Towson Maryland 21. Si pa re of Yun ral a rvide Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 100 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouse, and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a co Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has b lirector, page 2 sl autopsy perform death? 2 🗌 No Yes 25. Was case referred to medical æ 26. Place of Death Check only one 2 **N**0 Other: 1 Tyes 잍 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗀 No Investigation
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State, hin 24 hours a **the Funeral Γ** πpleted filled Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only/one) 29b. Signature and title of certifi igned (Month, Day, Year) 30. Name and address of

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 2012 JANUARY 09:30PM BENJAMIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE PIKESVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) 12/15/1914 1 □ M 2 🛛 F Min Director 219-32-4772 97 NY Usual Residence of Decedent show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthment of Health and Mertial Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3430 ASSOCIATED WAY, #210 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 MANAGER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY SOKIL FANNIE DREFKO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY BLOCK / DAUGHTER 3430 ASSOCIATED WAY, #210, OWINGS MILLS. MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) FORBAND CEMETERY 01/31/2012 ROSEDALE, MD Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 9 8900 REISTERSTOWN ROAD. PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Provincian disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy perform Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X Nc ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA sing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending iniury work? 2 🗆 No Investigation M | Director: / d in by the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 within 7

State Registrar

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, P int)

DHMH 17 Rev 7/2009

TIMOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 1 per dr. g928 6/8/12 dentificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1237 Physician/ Month Nalij Lavaun Boyd-Grimes-Kalij La'Vaun Grimes AM 27 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death n/a Dr. Bob's Place Baltimore 5. Social Security Number unk Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreigh Country) Months Hours Director 1 □ M 2 😾 F 22 01/05/2012 MD Usual Residence of Decedent 28a-f show 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 2601 Spelman Road Apartment A3 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. 14. Race - American Indian, Armed Forces Black, White, etc. 0. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify Black 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than O Elementary/Secondary (0-12) College (1-4 or 5+) n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tempey Silvania Boyd Karlton Leevaun Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Spelman Rd #A3 Baltimore, MD 21225 f Health item 27 Tempey Boyd-Grimes Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donution 5 ☐ Other (Specify) cemetery, crematory or other place) Greenmount Crematory | 02.02.2012 | Baltimore, MD ig sture John L. Williams Funeral Directors, P.A. 4517 Park Heights Avenue Baltimore, MD 21215 . Enter the disease, or complications that The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cause on each lir Immedia e Cause (Final Sweeks Physician/ SOMY Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying me Examine Due to fur as a consequence on Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 ■ No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 🗆 Yes 2 🗆 No 1 Natural injury 5 Pending Accident Investigation Funeral Director: A ☐ Accide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a 29d. Date signed (Month, Day, Year) mou 056211 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanover St. Baltimore, MD MS 3001 John 32. Registrar's Si Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Physician/ 12:30 P M January 19, 2012 Franklin Caffee Brockway Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery Gaithersburg Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1X M 2 □ Months Days Hours Min. Augunth 2024, Year) 917 700-09-6012 94 Wfsconsin Director Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue Room 240 20877 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced SpecifyWhite Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Health Services Grant 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator <u>US Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Franklin Caffee Bessie Annabelle Woodworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21517 Quick Fox Lane, Laytonsville, MD 20882 David Caffee (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 X Cremation 3 D Removal from State 1/20/2012 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, an 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shick, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition Onset and Death Physician/ arhinson cons Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): 10 attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🕅 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation M 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2012 aNUAL person who completed cause of death (Item 23a) (Type, Print) Mc State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARTER ILLIE よるか Zorz 2 Medical **Examiner** 4a. Facility, Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death OSPITAL ALTIMORE B If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 5 Morth, Day 5. Social Security Number 249.68-1856 7. Age (In yrs. last birthday)
67 Yrs. **Funeral** 9. Birthplace (State or Foreign Months **Director** Country) Usual Residence of Decedent or 28a-f show notified at 10b. County filed within 72 hours after death with the Maryland City, Town or Location 10c 10d. Inside City Limits Director Baltimore atonsville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 21228 USA $m\omega n$ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during ife. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) nemica orker Be 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မှ Page 1 and 2 should be Harvey Carter Jr. Ne tima 1800 Name/Relation nip (Type, Print) Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) atonsville, MD Bru cestown ourt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometen, cremator) or other 20c. Loçation - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State or other place) 2-4-12 4 Donation 5 Other (Specify) permit. . Signalure of Funeral Service icensee Furerral Pike Balto Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 6 CARDIAL 1 FANCTION disease or condition resulting in death) Medical Examine 0~ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions equiributing to death by net resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RUA Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☒ No Other: |@ ER/Outpatient 3 DOA 1 Inpatient 2 🗌 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After th filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29c. License number 2012 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 21217 95 OSEPH & CA BACTINITE 51 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G924 2/09/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07 (ontes Physician/ K Month Margery 7:104 Jandan Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 608 Lewis Street Havre de Grace Harford 8. Date of Birth (Month, Day, Yes Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Director 182-18-5436 1 ☐ M 2 💢 F 1919 Maryland 92 Yrs. 23a or 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖵 No MD Harford Harve de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 608 Lewis Street 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wto. rtal Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th unk unk homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Friedrich Heyn Kelly Vida kelly Bloede ge 1 and 2 should b nt of Health and Mer t: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Country Club Rd; Havre de Grace, MD 21078 Daniel Coates - son Department of Heal Important: If it 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Rona Id 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ multiple Myeloma disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Physitin 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier nshijapehum.D 29d. Date signed (Month, Day, Year) 20057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltoman MD 2709 NS Rejapt BEMID. 703 2835 Smith A 32 Registrar's Signature State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per inf g927 5-7-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar 02497 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 28, 2012 Jack Jim Cano 2226 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth May 30, 1930 **Director** 571-85-3589 1 XM 2 □ F 81 Usual Residence of Decedent 28a-f show 10a. State with the Maryland notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 🗆 Yes 2 💢 No 10e, Street and Number ò 10f. Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral 5225 Pooks Hill Road #1405 North 20814 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
 Item 27 is marked other than "natural", or items lury or other fraumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Officer Iranian Military Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mohamad Mehdi Amirkiaee မ Mohmad Amirkiee Roghich Amirkico Savedeh Robabeh Amirkiaee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5225 Pooks Hill Rd. #1628 South Bethesda, MD 20814 Mahmoud Salmani/son in law Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 01/31/12 Woodbine, MD 21. Signature of Funeral Service Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 45piration Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner rastersintestinal if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last anding physician ause as the burial-Physician/Medical Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month signed by the at Id be detached for Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed? Yes 2 (A) 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျပ 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature apartle of certifier 29c. License number 6626 4) 01/29/12

Registrar

DHMH 17 Rev 06-2011

State

mane:01) orece

ano, Jack

Old

GEORGETOWN Rd BETHESDA, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

8600

A. park

32. Registrar's Signature

Pirouz

31. Date FEB 0 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Physician/ 2:27 PM JANUARY 27 shia ane 2012 ema Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Peath **Examiner** Memorial NIA altimore Hospita Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days **Director** 1 🗆 M 2 🔀 🗗 26Yrs. Baitmore Nov 28a-f show 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Wes 2 No Itimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Blac If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Morgan Be 18. Mother's Name (First, Middle, Maiden Şurname) 17. Father's Name (First, Middle, Last) ည Department of Health and Ment. Important: If item 27 is marked any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) anielle 4032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign tire of Funeral Service 22. Name and Address of Facility 5014 More 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of the burial-transit and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has to the Funeral Director. After this page 2.8. autopsy performe 1 ☐ Yes 2 🗙 N 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 1 🗌 Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 1/30/2012 AT 2438946-BII 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emily RYAN 201 University Parkway Baltimore, MD 21218

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

FEB 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jesse James D	xon	1- For State Registrar	State	of Maryla		artment of <i>rtificate of</i>	FHealth and F <i>Death</i>	Mental H	_	eg. No. 20	112 0249	
Physici Medical Exam											3. Time of Death 1154 hrs	
7		4a. Facility Name (if not institution, give street and number) 3 Lemon Grove Court # A 4b. City, Town, or Location of Death Cockeysville								4c. County of Death Baltimore County		
Funeral Director	ī	5. Social Security Numb	_		7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	-	th (MM/DD/YYYY)	Birthplace (State or Foreign	
		242-06-19 Usual Residence of De-		M 2 F	45	Yrs			10/25	/1966	Country) NC	
l E. E.			o. County			Town or Locati				-	10d. Inside City Limits 1XXYes 2 No	
Marylane 28a-f sh	Director	MD 10e. Street and Number	Balt:	ımore	<u> </u>	ockeys	10f. Zip Code		1	0g. Citizen of Wha		
ith the 1 23a or 100tifie		3 Lemon	Grove		edent Ever in U	S 142 W/o	210			USA		
2 hours after death with the Maryland "natural", ar items 23a or 28a-f shuw Examiner must be notified at once,	Funeral	1 Never Married	2 Married				s Decedent of Hisp es, specify Cuban,			- 14. Race - White,	American Indian, Black, etc.	
ours after ttural", aminer	Š	3 Widowed 4		if Yes, Give Year or Dates: nly highest grad			Yes 2 No	·	ork done	Specify: 16b. Kind of Busin		
36 nin 72 ho e. than "nu ddcal Ex	Completed	Elementary/Secondar	ary (0-12)	College (1-	4 or 5+)		ost of working life. [ĺ	T		
NOTE, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Heatth and Mental Hygiene. 12 If Item 27 is marked other than "natural", nr Items 23a or 28a-f shun uther fraumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First			-	Pain	t Mixer			Lemar P Maiden Surname)	Paint Co.	
2121 ould be i I Mental	To Be	Jesse J. 19a. Informant's Name/F				19b. Mailing	Address (Street a	Caroly: and Number or R	n Y. W ural Route Num	atson ber, City or Town,	State, Zip Code)	
and 2 sh ealth and tem 27 is	15-3	Carolyn 20a. Method of Dispositi	Dixon		20b. F	3 Le	mon Gro	ve Cou	rt, C	ockeysv	rille, Md.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked nither than "natural", ur items 22a or 28a-f shu injury ur nither traumante event, the Medical Examiner must be notified at once.		1 XXBurial 2 C		Removal fro	m State	rematory or oth						
Balti permit. Departri Imports		21. Sign-ture of eral		see,	1100	22 N ES	ame and Address of tep Bro 00 Euta	f Facility thers	Funera	l Servi	ce, PA	
Physician /Medical		23a. Part Eller the dis	sease, or compo	ichtions that car ch line,	used the sath.	Do not enter th	e mode of dying, su	W PIACO uch as cardiac or	e, Bal respiratory arre	TIMOPE, est, shock, or heart	Md. 21217 Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final or condition resulting in	il disease a. n death)	Hyperte Due to (or as a	nsive C	ardiova	scular D	isease		-	Death	
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
0.5	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
io, e be executed ysician and burial - transit	edical E	X UNPENDED	d.	AMENDED 2	3a.nt.T	T. 27. ne	r me,g924	2-3-12	Cm			
760, cate be exphysician	/Medi	IF FEMALE: 23b. Was decedent pregr	unant in the	23c. If yes, or	utcome of pregr		1 1110,672	. 2 3 12	ЭШ	23d. Date of de	alivery	
Box 6876(e death certificate the attending physical for use as the b	Physician/M	past 12 months?		1 Live bir 4 Pregna	th nt at time of dea	- H	al death 3 er (Specify)	Ectopic pregnar	ncy	Month	Day Year	
Trithe d		Part II. Other algnifican		9 Unknov		sulting in the ur	derlying cause give	en in Part I.	23e. Did tot	pacco use contribu	ite to the cause of death?	
ls, P.O. quires that then the signed by all the detach	ed by	Diabetes	Mellit	us							Probably 4 Unknown	
e law require has been ge 2 should	Completed								24a. Was a autops	prio ned? dea		
tal Rec	မ်ို့ မြ	25. Was case referred to examiner?						Death (Check or	1 Yes 2	No 1	Yes 2 No	
Division of Vital Records, tal or Attending Physician: The law requir ns after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the	의	1 Yes 2 27. Manner of Death	No	28a. Date of	f Injury	ER/Outpatient 28b. Time of In				Residence 6 🗹 0		
Sio Vitten deat ctor	catio	1 Natural 5 Accident	Pending Investigation	(Month, E				2 No				
Divi	Certification:	3 Suicide 6 Homicide	Could not b	e (Specify)	or injury - At no	me, rarm, street	factory, office build	ding, etc.	28f. Location (SI or Town, St		or Rural Route Number, City	
Divi: To the Hospital or 4 within 24 hours after To the Funeral Dive	ᇙᅵ	29a. Certifier 1 Certifier (Check only one) 2 Medi	ical Examiner:	On the basis of	examination an	e, death occurre d/or investigation	ed at the time, date on, in my opinion, de	and place, and c	lue to the cause the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)	
F 1 8 1 8	Wed	29b. Signature and title o	of certifier	and manner sta	tea.		29c. License n				(Month, Day, Year)	
4	-	30. Name and address of	f person who co	ompleted cause	of death (Item 2	23a)	O.C.M.	E.		January 18, 2	:012	
Y		Laron Locke MD					imore Street, I	Baltimore, M	D 21223			
Sta Registi	ar	31. Date Lead March, Pa	2012	Zur Reg	strar' Signatu	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Januar Sarah Elizabeth Diem 2 2012 /Medical County of Death 4c. or Location of Death Facility Name (If not institution, give street and number) 4b. City, Town Examiner LCA Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 6 Sev Age (In yrs. last birthday **Funeral** Min Months Days Hours 1 ☐ M 2 💢 F 1920 Tenessee 10, Oct 91 Director 240-05-0810 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10a. State ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinor must be routlied at 1 ☐ Yes 2 ☑ No Director Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 555 S. Attwood Rd #415 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, Inc. 1008. 0 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joel Lucius Emerson Francis Sartilla White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 609 Charwood Ct; Edgewood, MD 21040 Stephen Diem - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Sign tu of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or las a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? us certificate has been signed director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this o Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier соmpletely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature